Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, September, 1949 Vol. 26 No. 9

Obiter Dicta

The Ottawa Civic Investigation

ELSEWHERE in this issue we report on the public enquiry into the charges by the Ottawa *Citizen* that the Ottawa Civic Hospital was mismanaged and inefficient and that there was lack of co-operation between the employees and the doctors. It will be pleasing to the many friends of this institution that it has been fully exonerated of the charges and in such a strongly worded report by Judge McDougall. It must have been gratifying to the hospital to see so many former patients come forward voluntarily and offer to testify on behalf of the hospital. And it must have been equally gratifying that not a single member of the medical profession had any criticism of the operation of the hospital.

This attack by the Ottawa *Citizen,* which proved ultimately to be not only a dud but a boomerang, cannot help but do a good deal of harm not only to the Ottawa Civic but to all hospitals. People remember the criticisms, no matter how much discounted by the learned Judge, and quickly forget his assurance that the enquiry did "not to any degree whatever disclose any situation in the hospital which need give the slightest worry to the public". This possible effect on the public was deplored by the Commissioner. Fortunately this hospital has long enjoyed good press relations with the other English language newspaper, for its former board chairman, Mr. Norman Smith, was for many years Editor of the Ottawa *Journal.*

That patients now and then will be critical is a situation that cannot be entirely overcome no matter how perfect the organization or how capable the staff. Hospitals today have considerably more staff than they have patients and no administrator of a hospital as large as the Ottawa Civic can hope to have over a thousand employees without having one who may be a little brusque or seem unsympathetic to a patient, or even *be* unsympathetic at times. Unfortunately, too, most nurses have only one pair of hands and one pair of very tired legs and it is not always possible to answer half a dozen bells at once, or to be in three places at the same time. When things happen in a hospital they always seem to happen at the same time and nurses must use their judgment as to what to give first attention. They can hardly be blamed if they become impatient with some not-very-sick but insistent patient, when they are very busy with someone desperately ill. Many patients are easily upset when ill and it would not be too difficult for a critical paper to collect a number of instances of alleged neglect. It is hard, however, to condone the publication of

charges without first checking on the validity of these complaints, or an investigation, having been precipitated, to fail to produce the evidence and then to take the viewpoint that it is not one's responsibility.

To Dr. Douglas Piercey, Miss Edith Young, and Dr. H. Featherston, we extend our congratulations on this vindication of their stewardship.

On the C.M.A. Attitude Toward Hospital Care Plans

AT its June convention in Saskatoon the Canadian Medical Association adopted a "Statement of Policy" with respect to the economics of providing medical care. Certain implications have been read into the last two clauses (particularly Clause 7) of this statement, leading to strong criticism of the Association for recommending a compulsory prepayment plan for hospital services, by inference, at the expense of voluntary hospitalization plans. This has been noted particularly in Alberta where the Blue Cross plan is bounded east and west by compulsory government plans and is hamstrung at home by a government which refuses to let the voluntary hospitals get any federal or provincial construction aid unless they municipalize their finances.

The clauses in question are:

6. The Canadian Medical Association, having approved the adoption of the principle of health insurance, and having seen demonstrated the practical application of this principle in the establishment of voluntary prepaid medical care plans, now proposes:

(a) the establishment and/or extension of these plans to cover Canada;

(b) the right of every Canadian citizen to insure under these plans;

(c) the provision by the State of the Health Insurance premium, in whole or in part, for those persons who are adjudged to be unable to provide these premiums for themselves.

7. Additional services should come into existence by stages, the first and most urgent stage being the meeting of the costs of hospitalization for every citizen of Canada. The *basic part* of the cost should be met by individual contribution, the responsible governmental body bearing, in whole or in part, the cost for those persons who are unable to provide the contribution for themselves.

We have discussed this matter at some length with representatives of the Canadian Medical Association and are assured that the Canadian Medical Association has had no intention of deprecating voluntary hospital insurance, as contrasted with compulsory insurance. To quote the Assistant Secretary, Dr. A. D. Kelly, "The benefits of hospital care insurance were so evident that this form of coverage was, by general consent, agreed to as a desirable thing. General Council refrained from indicating whether this coverage should be afforded on a voluntary or a compulsory basis but, by inference, the endorsement of voluntary prepaid medical care at paragraph 6 would certainly not indicate any antagonism towards the activities of Blue Cross." It has been explained, too, that those unable to afford existing voluntary plans should be permitted to do so by having their premiums paid by governments and that this was implied by the C.M.A.

We are glad to have these interpretations, for the Canadian Medical Association endorsed the prepayment hospitalization movement back in 1935, when other medical bodies were still opposing these plans, and we would be sorry if that important organization had reversed its position.

It does seem to us, however, that these clauses have become so vague in the obvious effort to get a wording that would be acceptable to many shades of thought that a wide range of interpretation could be made. The "plans" referred to in clause 6(a) and (b) are obviously voluntary prepaid medical care plans; there is no indication that "medical care" is meant to include hospital care as well. But in Clause 7 it is difficult to make any other interpretation than that the reference is to compulsory government-sponsored plans, contributory in nature and with the government bearing the cost for those unable to provide their contribution. This would be in accord with the position taken by the Canadian Medical Association in its presentations at the health insurance sittings in Ottawa several years ago. One can hardly do otherwise than interpret these clauses as indicating a desire to keep medical care plans on a voluntary prepayment basis for the time being, but to be agreeable that hospital care should be provided by a compulsory prepayment plan, covering all people and financed in part by premiums and in part by government funds; in other words, essentially what has been developed in Saskatchewan and in British Columbia. We anticipate that this will be a widespread interpretation of Clause 7.

The General Council of the Canadian Medical Association is perfectly within its rights in setting forth a statement of policy. We have often wished that it would do so more frequently and on more subjects; although, in this instance, we would wish that its statement had been less open to varied interpretation. The soundness, or otherwise, of the recommendations is not under comment here. The groups making up the Canadian Hospital Council will themselves have varied views on the relationship of governments to the financing of hospital operation and many individuals would favour a compulsory plan if efficient and fair operation be assured. But Clause 7 does seem to indicate a willingness, or even a strong recommendation, that hospital care plans should come under the state, while 6(a) would keep medical care plans on a voluntary basis. As this apparent attitude hits hard at the Blue Cross plans now operating in Canada, supporters of these voluntary hospitalization plans are asking why the national medical organization should be so ready to turn over hospital care to the state (but not medical care) without first consulting the hospital field. They ask, if state sponsonship for hospital care is desirable now, why not for medical care? One medical correspondent, who interprets Clause 7

as an advocacy of a state hospital plan at the expense of Blue Cross, puts it: "I am wondering what the reaction of the Canadian Medical Association would have been if the Canadian Hospital Council had passed a resolution recommending the socialization of medical services and state control of the medical profession?"

What is Meant by "the Chronically Ill"?

THE National Health Program has focussed attention on many points probably not anticipated when its clauses were drafted. An example is the necessity which has been revealed by the provincial study committees for a clearer understanding of just what is meant by the phrase "the chronically ill". When does an acutely ill patient become chronically ill? Can we set a transition point of so many days or weeks? Are those who are incurable also chronically ill, or, for the purposes of classification, can we put the former in another group? We say that, except in quite large centres, the chronically ill should be treated in a building adjacent to an active general hospital or perhaps a wing of that hospital, to ensure ease of diagnostic study, better medical and nursing supervision, and better therapeutic facilities. Do we mean only those who can obviously be improved by the better diagnostic and therapeutic facilities and the (likely) better medical supervision, or would we admit also the incurables?

And this leads one to question the meaning of what is described, in improperly used English, as a "chronic bed". This is important for, with $1,500 instead of $1,000 available from the Federal government for beds for the chronically ill, and with at least that amount to come from the Province, a number of general hospitals are asking for the larger per bed amounts to build "chronic wings". Governments are asking what assurance can be given to them that these beds, for which larger grants will have been obtained, will be used only for the chronically ill. Have they any clear-cut idea themselves? No definitions on a national basis have been worked out by the hospitals.

If incurable patients are to be admitted, the monthly turnover soon will be practically nil except as the grim reaper finally intervenes. If only those who are likely to show some definite improvement under treatment are admitted (such as diabetics, cardionephritics, asthmatics, and arthritics) more patients could be given care in the "chronic wing". This would seem to be a wise policy, for the basic idea of having the chronically ill housed close to the diagnostic and therapeutic facilities of an active treatment hospital is to encourage better medical supervision. But if this policy is followed, some accommodation elsewhere must be provided for the incurable. It may well be that, for much of a province, hospitals for incurables would be less numerous than the wings or annexes for the chronically ill. In large centres, the most practical plan might be to continue to combine the chronically ill and the incurable in one special hospital, provided adequate diagnostic and treatment facilities with good medical supervision and nursing are provided.

What is a Public Ward?

IN these days of increasing uniformity in the use of terms and of general standardization, some clearer understanding might be reached with respect to what is meant by a "public ward". In the days when public wards held thirty to forty patients, the problem was not a difficult one, but today size is not so obvious a factor. Many smaller hospitals today have no rooms holding more than three and in some cases, two beds. Strictly speaking these latter hospitals really only have private and semi-private rooms. Yet, on the other hand, there are hospitals with "semi-private" rooms holding up to four and actually five beds! The old idea that a semi-private room was one with two beds seems to have long since disappeared.

A factor in this loose use of terms may be the financial one. Some compensation boards and other bodies have insisted on semi-private accommodation, and have been allotted these larger "semi-private" rooms. Would they not be more accurately described as the modern type of smaller public ward? Blue Cross is interested, too, for some hospitals provide the patient paying the semi-private rate with accommodation compared to that provided by other hospitals to patients paying public ward premiums. And the first hospital collects more from the Blue Cross if the "going rate" is paid. An extreme example of the loose application of terms is the designation "two-bed private" rooms! A patient is either given private accommodation or he isn't, and no high sounding terms can minimize the snoring or the annoyance of the noisy visitor on the other side of the screen.

Again, too, the percentage of patients in public wards who are indigent varies with the prosperity of the times. Among those for whom something is received beyond the municipal and provincial payments, the percentage who pay out of their own pocket is steadily falling. More and more have their way paid for them by Blue Cross, by industrial plans and other prepayment arrangements, and now by governments. As this type of accommodation is becoming recognized as the basic type in these rapidly spreading arrangements, it would seem better to have public wards known as "standard" wards. We note that this terminology was accepted at the conference on statistical returns called by the Dominion Bureau of Statistics last winter. Undoubtedly, too, this standard type of accommodation will steadily improve in equipment and comfort; already it bears little resemblance to the public wards of but a generation or two ago.

MODERN POST-ANAESTHESIA

1. Benefits to the Patient and Staff

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THE post-anaesthetic recovery room has established its merit by providing improved medical care. Before it became a part of the modern hospital, patients sometimes died immediately after the operation, on elevators or on trips through long corridors. The explanation for this unfortunate result is simple: the probable cause of death was respiratory obstruction, lack of immediate oxygen therapy, blood loss, or shock. In some instances, death occurred in a remote ward before medical aid could arrive. Often patients who have not died from these causes have had a more protracted hospitalization and convalescence because of delay in urgently needed treatment. During the operation the patient is under the constant vigilance of the anaesthesiologist who administers the anaesthetic, carefully observing and controlling the respiration and circulation; even after the last suture has been tied, this type of care should not be permitted to elapse, for the recovering patient at times hovers for hours between life and death. So delicate is this vital balance that a slight delay in treatment may prove fatal.

Every administrator knows that the lower the mortality and morbidity rate, the greater the prestige of the hospital. Apart from this, it is his duty to the public to furnish the best possible facilities for efficient medical care. For post-operative cases he can do this readily by providing a recovery room which is, in effect, a part of the operating suite. Thus it is possible for expert personnel to maintain a close supervision of the recovering patient; they are adequately supplied with efficient equipment concentrated in this one room of the hospital. The recovering and often still anaesthetized patient is observed and nursed by a graduate nurse who is trained to detect the signs of failure. Both surgeon and anaesthesiologist are readily available to guide the medical care.

Procedures

During these few critical post-anaesthetic hours the anaesthesiologist attempts to maintain, or to restore to normal, respiration, circulation, and temperature.

Resumé

Tout administrateur sait que le plus bas est la proportion de mortalité et de morbidité, le plus grand est le prestige de l'hôpital. De plus, c'est le devoir de l'administrateur au public de leur fournir les meilleurs facilités possibles pour les soins médicaux. Pour ceux sur qui on a opéré il peut faire ceci en ayant une salle de recouvrement. Ainsi, il est possible pour un personnel habile de surveiller l'opéré. Ce personnel a tout l'équipement nécessaire dans cette seule chambre de l'hôpital. Le malade qui commence à revenir et est souvent encore anesthésié est observé et soigné par une garde-malade qui connait tous les signes qui indiquent que le malade commence à faiblir. Le chirurgien et l'anesthésiologiste sont tout près pour le soigner immédiatement dans un cas urgent. ●

Attention is usually given first to *respiration.* This includes the maintenance of an open air passage by the aspiration of secretions or blood from the pharynx, by proper posturing, or by the use of an oropharyngeal airway or endotracheal tube. Preservation of this free air passage precludes to a large extent the onset of pulmonary oedema and anoxia.

If a patient is cyanotic, an examination is made of the thorax for the detection of *atelectasis.* Cassels recorded in six thousand operations eighteen instances of atelectasis on the operating room table. However, some instances are not detected until the patient arrives at the observation room. The cure is effected usually by the following means: encouraging coughing, administering inhalations of 5 per cent carbon dioxide in oxygen, moving patients from side to side every hour, encouragement of deep breathing by exercises, intercostal nerve blocks, or the intravenous injection of 5 cc. of coramine. In persistent cases of atelectasis, aspiration of the trachea or bronchoscopy may be necessary.

During the first post-operative hours, careful observation of circulation is made. The state of the circulation can be estimated roughly by three methods: pulse rate, blood pressure, and the refilling time of the capillaries. Patients may exhibit varying degrees of shock ranging from mild to extreme. Those with the latter have cold, clammy, pale, and cyanotic skin, and a very slow capillary refill time, especially in the extremities. The blood pressure is low, the pulse pressure decreased, and the pulse rate rapid. Blood trans-

RECOVERY ROOM SERVICE

fusion may be necessary. If the infusion rate becomes rapid it is a danger sign. It is in these instances that intra-arterial infusion has shown its value. Frequently patients are observed with warm flushed skin and rapid capillary refill time, but with low blood pressure and slow pulse rate. This is especially true after spinal anaesthesia where the vasoconstrictors are paralyzed. These patients are not in true shock since the pulse rate is not rapid. An analeptic, such as ephedrine or methedrine, is required.

One of the most important advantages of the recovery room is the ready availability of efficient *oxygen therapy* for any of the cases with anoxia, whether respiratory or circulatory in origin. There are three common methods of administering oxygen therapy. Oxygen by mask method supplies possibly the highest oxygen tension and may be essential in extreme depression. Oxygen therapy by the tent method will provide concentrations of 40 to 50 per cent oxygen with a 14 or 15 liter flow. The third method of oxygen is by nasopharyngeal catheter. The

(Concluded on page 84)

2. *Organization and Equipment*

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THE post-anaesthetic recovery room (P.A.R.) has become an almost essential service for any hospital treating surgical patients. The surgeon is more satisfied when his patient remains in the custody of the anaesthesiologist and is cared for by specially trained nurses until fully recovered from the effects of surgical shock and the anaesthetic agent. With the increased demand for surgical beds in most of our hospitals there is good reason for hospitals to spend every effort in speeding the recovery of all surgical patients as this assists in reducing the average day's stay for these cases.

In the accompanying article the director of anaesthesiology at the Vancouver General Hospital emphasizes the benefits to patient and doctor accruing from the establishment of a post-anaesthetic recovery room service by reason of the improved treatment at a time when the patient is in a hazardous period of recovery. The nursing department of the hospital also benefits very materially from the operation of a P.A.R. The floor nurses are no longer required to interrupt their regular routine work in order to devote additional attention to patients returning from the operating room. Much of the confusion on surgical floors is eliminated. In a busy hospital there is no substitute for the post-anaesthetic recovery room.

At the Vancouver General Hospital we first established a post-anaesthetic recovery room by very timidly transforming a four-bed ward into a seven-bed P.A.R. service for our main operating rooms. The illustration shows one corner of the new private ward recovery room which was opened in February of this year. This room contains twelve beds; it has two dressing rooms with four lockers in each so that many male and female short stay cases can be admitted directly to the operating room area for such surgical treatment as varicose vein ligations and brachial blocks. It is well equipped with good suction from a central unit piped to each bed, oxygen tanks with masks and catheters, intravenous stands, a resuscitator, bed warmers, and other equipment necessary for the care of the post-operative patient.

In March there were 270 patients treated in this new room and the results have been outstandingly satisfactory—so much so that we are now planning a larger and more elaborate P.A.R. for our main operating rooms. The one major change in the new service will be the introduction of a utility room with a bed pan washer-sterilizer and a small instrument sterilizer.

The hospital is the doctor's workshop and it is the responsibility of the administrator to provide the best possible working conditions for the benefit of the patient. To assist others who may be establishing a P.A.R. service for their hospital, we are outlining the minimum requirements for space, personnel, and equipment.

Space Required

It has been our experience that it is not necessary to allocate a large area for the establishment of a post-anaesthetic recovery room. An excellent service can be given in a small area and such an arrangement may handle a large number of cases. After all, the unconscious patient does not require the normal nursing or usual dietary services and takes no interest in his environment. As stated above, our first recovery room was set up in a four-bed ward which was adjacent to our main operating rooms. Seven or eight patients are normally found in this room in the mornings and this room is still being used to evacuate half of the

patients from seven of the main operating rooms.

As a general guide in planning a recovery room, we would say that the area should contain one bed for each operating room and that the length of stay in the recovery room is approximately the same as the time the patient spends in the operating room. After a one-hour operation the patient can usually be evacuated to the nursing floor in one hour. Tonsilectomy patients are an exception and usually they spend two or three hours in the recovery room. In addition to the beds, there should be enough space for a nurse's desk, an instrument cupboard, a linen cupboard, a cupboard for side boards, and other equipment and utensils. It has been found quite satisfactory to care for both male and female patients in the recovery room. All employees work better when they have adequate room in which to perform their duties and they appreciate good equipment; do not hesitate, however, to set up a P.A.R. even if space is limited.

Organization and Personnel

Post-anaesthetic recovery service is basically a nursing service and this activity should be under the jurisdiction of the operating room supervisor. The patient is under the care of the recovery room nurse until returned to the regular nursing unit; with this form of organization, it is found that operating room nurses are available for relief or extra assistance when required. The surgeon and the anaesthesiologist are responsible for the professional care of the patient and one or the other authorizes the return of the patient to his ward. An anaesthesiologist should be on duty in the vicinity and readily available until all patients are removed from the recovery room.

The personnel required for a recovery room of from five to ten beds would be:

(a) A graduate nurse especially trained for this work by the anaesthesiology staff;

(b) An orderly to assist with male patients and to prepare short stay cases if such service is to be given;

(c) A nurse aide to assist the nurse and attend to supplies.

In a small hospital where it is not feasible to establish a separate staff for this service it is still advantageous to have a small recovery room adjacent to the operating room so that post-surgical cases can be concentrated in one area until it is safe to clear them to their respective rooms.

Special nurses are permitted to care for their individual patients in the recovery room. However, it must be understood that they are under the direction of the recovery room nurse while working in that area. Visitors are not permitted in the recovery room unless the patient is critically ill.

Equipment Required

It is not necessary to purchase expensive or special equipment to set up a post-anaesthetic recovery room. All of the items needed for post-anaesthetic care are already on hand in all hospitals; but by concentrating them in one area their effectiveness is increased many times because they are right at hand when urgently needed. In some cases it might be necessary to duplicate equipment already in use in the hospital, but there are certain items that should be readily available for the care of the post-surgical patient and the patient benefits by being in a room well supplied with necessary equipment.

Beds: It is not necessary to purchase beds for the P.A.R. because, when the patient is transferred to the stretcher or operating table, the bed is taken to the P.A.R. and prepared for the reception of the patient after the operation. It is better practice to take the patient to

(Continued on page 84)

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Post-Anaesthetic Recovery Room, Vancouver General Hospital

Resumé

Comme guide général dans le tracement d'un plan pour une salle de recouvrement, nous dirons que la salle devrait contenir un lit pour chaque amphithéâtre et que le malade devrait rester dans cette salle à peu près le même temps qu'il est resté dans l'amphithéâtre. Après une opération qui a duré une heure, son séjour dans la salle devrait être une heure. Les malades, à qui on a enlevé les amygdales, sont une exception. Ils devraient rester deux ou trois heures. De plus que les lits, il devrait y avoir dans la salle un pupitre pour la garde-malade, une armoire pour les instruments, une autre pour le linge, et une troisième pour l'équipement et les ustensiles. On a trouvé qu'il est possible de soigner les hommes et les femmes malades dans la même salle de recouvrement.

Tous les employés travaillent mieux quand ils ont assez de place pour travailler et ils apprécient du bon équipement; mais n'hésitez pas d'établir une salle de recouvrement même si votre espace est limitée. •

Dr. A. K. Haywood

to receive

Stephens Memorial Award

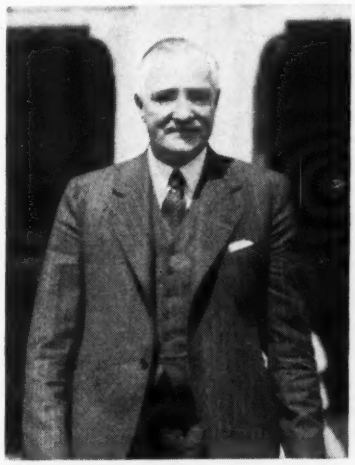
THE Executive Committee of the Canadian Hospital Council has agreed unanimously to confer the first *George Findlay Stephens Memorial Award* to Dr. Alfred K. Haywood of Vancouver. This award has been set up to honour the memory of the late Dr. George F. Stephens of Winnipeg and Montreal.

The award is to be made from time to time for noteworthy service in the realm of hospital administration. Priority is to be given to consistent service and leadership over the years rather than for a single contribution or achievement. The award shall be in recognition of personal efforts to advance the efficiency and welfare of Canadian hospitals, to improve administrative methods, to develop national or provincial organizations, to provide assistance to other hospitals, to foster better public relations for the furtherance of social and other legislation relating to hospital care, and for efforts to advance administrative policies in general.

Dr. Haywood has long been a leader in the Canadian hospital field. Born in Toronto and educated there, he obtained his M.B. Toronto in 1908 and his M.R.C.S. and L.R.C.P. in London in 1911, continuing his studies in England, Germany and France until 1912. He was assistant superintendent of the Toronto General Hospital from 1912 until the outbreak of war when he joined up, serving overseas until 1917. He received the Military Cross for exploits in the field in 1915.

He then returned to Canada and became general superintendent of the Montreal General Hospital, a post which he held with distinction until 1930, when he resigned to take over and re-organize the Vancouver General Hospital. He retired from that position in 1947.

During his years in the hospital field "Alf" could always be counted upon to back worthy movements with enthusiasm. He was one of the founders of the Montreal Hospital Council, and was the first chairman of the committee directing the work of the Department of Hospital Service of the Canadian Medical Association. He worked hard to establish the Canadian Hospital Council and served for many years on its executive committee. He could always be counted on to liven up the Council sessions. Directors of small hospitals always found in him a friend who was never too busy to delve into their local problems. Frequently he was called upon to conduct surveys of sister institutions, a task he performed with intelligence and conscientious study. A former vice-president of the American Hospital Association, he has served on its Board of Trustees and on various committees. He is a Fellow of the American College of Hospital Administrators and was for some time the Regent for Western Canada.



Dr. Haywood

Not content with providing leadership in the hospital field, Dr. Haywood has maintained a broad community interest. While in Montreal he was chairman of the Committee of Sixteen set up to stamp out vice and the drug traffic in that city. It was a tremendous and, in fact, an impossible task, but they made such an impression that for some time Dr. Haywood's family was given police protection against possible retaliation. He has been active in the Canadian Social Hygiene Council, in the Canadian Red Cross, and in various local organizations. For his assistance during the recent war he was awarded an O.B.E. in 1946. One of his three children, Robert, was killed overseas while serving with the R.C.A.F.

One of Dr. Haywood's greatest contributions has been through his training of young men. His assistants have always had unlimited encouragement from the chief and have quickly assumed posts of considerable responsibility all over the continent. It is an enviable record that three of his assistants—Dr. Basil MacLean, Dr. Don Smelzer, and Dr. Peter Ward—have been honoured with the presidency of the American Hospital Association. It is of interest, too, that when Dr. George Stephens wished to learn something about running a civilian hospital in 1918, he went to Dr. Haywood who promptly put the newcomer in overalls and for six months gave him an intensive course in hospital operation.

The presentation will be made by President R. Fraser Armstrong of the Canadian Hospital Council during the meeting of the British Columbia Hospitals Association in November.

Superintendent Appointed at Guelph General Hospital

Mr. Menzie Dick, formerly assistant to the superintendent, Mr. Gordon A. Friesen, at the Kitchener-Waterloo Hospital, Kitchener, Ontario, has been appointed superintendent of the Guelph General Hospital at Guelph, Ontario. Prior to accepting his post in Kitchener, Mr. Dick had been business manager of the Saskatoon City Hospital, Saskatoon, Sask. He succeeds Miss S. A. Campbell, who retires this fall.

New Wing at Left

More Facilities Provided by
New Wing at St. Mary's, Camrose

DESIGNED to match the original structure, a new wing has been added to St. Mary's Hospital at Camrose, Alberta. It will provide an additional fifty beds, a 25-bassinet nursery, modern equipment, and operating room facilities. Soundproofed throughout, the three-storey brick building has steel beams and is of fire-resistant construction.

The hospital is operated by the Sisters of Providence, with Sister Superior Mary Alphonse in charge. It was under the direction of this Order that the original hospital was built in 1924. The fifty-bed institution, however, has for some time been inadequate to meet the growing needs of the district and when the new wing was opened on April 27th, a number of patients were immediately transferred from the old building to the new.

On the ground floor, there is a two-bed isolation ward and a physiotherapy room, in addition to a laboratory, barium kitchen, x-ray room, mortuary, and dispensary. An emergency operating room is to be found next to the ambulance entrance, and a medical staff and auxiliary meeting room, as well as engineer and orderly quarters are also located on this floor.

Private, semi-private, and four-bed wards for medical cases are on the first floor, as are the diet kitchen and administration offices. Surgical rooms and wards are found on the second floor. On this floor too is a children's ward with six cribs and an adjoining bathroom and shower. There are six clothes cupboards — one for each small patient.

The third floor contains the maternity ward and nursery, including an isolation and a premature nursery. There are two case rooms, two labour rooms, and twenty-five beds. The three operating rooms (two major and one urology) are equipped with the most modern facilities. The hospital is serviced by two elevators.

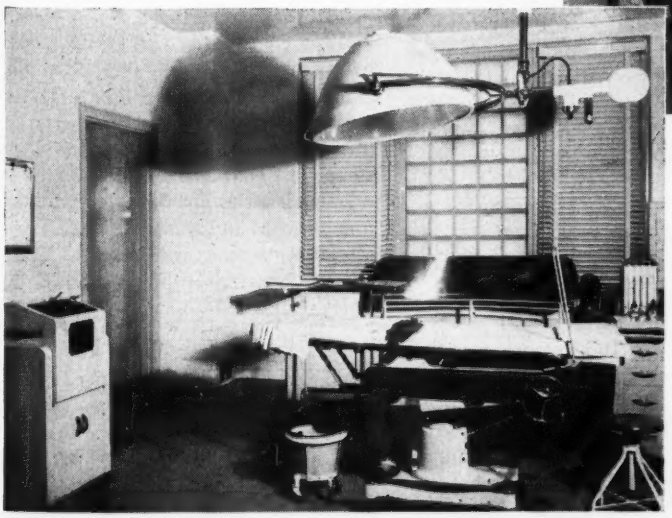
One of the features of the patients' rooms is a clothes closet for each patient. There are two cup-

The Chapel

Left: Nursery
Right: Semi-private Room

boards in the semi-private rooms and four in the wards.

An interesting note has been added to the rooms by the use of colour. The over-all colour scheme is pastel tones of primrose, baize pink, green, turquoise, blue, and ivory, with either light finished furniture or contrasting painted furniture. For example, one private room has green walls, white maple furniture, and a gold bed throw. One of the four-bed wards has two walls in green and two in cream; here the furniture is in two-tone green and bed throws are pink.



Centre right: O.R. Corridor
Above: Operating Room

The children's ward has two blue walls and two pink, with cribs in powder blue. All floors are covered with marboleum in various light shades.

It is planned to re-decorate the interior of the old portion of the hospital and when this is done it will follow the colour scheme of the new section.

Cost of the addition has been approximately $400,000 and cost of equipment $100,000. Architect was George Heath MacDonald of Edmonton.

Ottawa Civic Hospital Cleared of Charges

THE Ottawa Civic Hospital has been cleared of charges alleging maladministration and inefficiency in operation. A public enquiry, conducted by Judge A. G. McDougall and at which many witnesses were heard, has resulted in the Judge's conclusion that "the Ottawa Civic Hospital, having in mind all the conditions that affect that institution, is an efficiently operated and maintained hospital".

The enquiry developed as a result of two editorials in the Ottawa *Citizen*, which severely criticized the hospital. These editorials alleged inefficiency of administration and management, incompetence and inattention on the part of the nurses, and lack of co-operation between the hospital and the doctors. Because of the severity of the criticism and the mentioning of specific but unnamed instances, the trustees of the hospital requested the City Council to institute an official investigation. Approximately seventy witnesses gave testimony, many of them being former patients. Of these, a large proportion supported the hospital.

Criticisms presented by witnesses included those of unsanitary washrooms, delay in receiving personal attention or medication, unsympathetic and "brutal" nurses, improper handling of an outbreak of gastro-enteritis, laxity on the part of nurses, failure to supply breast milk, improper perineal care, dirty conditions in the labour room, errors in accounting, and a nurse who kissed babies.

Exonerates Hospital and Staff

Judge McDougall's findings were very much in favour of the hospital. He found "that the staff, both as respect the superintendent, the assistant superintendent, the superintendent of nurses, and the staff serving under them, are very serious-minded members of their respective professions". The Judge decided that it was inadvisable to deal with all accusations separately, because he found several factors affected much of the evidence. The evidence of some was affected because of their upset physical and nervous condition while in hospital; others were under the influence of sedatives and other drugs at the time; some witnesses could be expected to be unreasonable in their demands upon the staff; and in other instances a factor was the difficulty experienced by the hospital in finding the employee involved after a lapse of one or two years or of having the employee remember the incident in question.

The Judge was quite definite in dismissing the evidence of one woman that nurses danced in the halls by stating, "I regard her evidence as absolutely unreliable". In another instance alleging lack of care in an abortion case, he found "the charges are entirely unfounded".

Lumping together some seventeen charges alleging lack of proper care by nurses, the Court stated, "while some of these complaints may have some foundation in fact, the total matters established is relatively speaking very, very small, and do not to any degree whatever disclose any situation in the hospital which need give the slightest worry to the public". His final conclusion was that with regard to the editorials published in the Ottawa *Citizen*, February 28th and March 4th, "I find these charges are not substantiated by the evidence and do not exist in fact".

Noting that some 22,000 patients a year are treated in this hospital and that the investigation covered three years, the Judge considered that the number of complaints, even if absolutely true, would not indicate anything like a serious condition in the hospital. On the other hand, he accepted the evidence of the hospital in many instances, indicating that "the complaints were entirely unjustified".

Shortage of Nurses

The Judge did deplore the shortage of nurses and that the nurses were overworked, although noting that the situation had been much improved. "The Board of Trustees has been entirely generous in the money they have voted for nursing services."

He wrote appreciatively of the "clear, straightforward manner without any apparent bias" with which Miss Edith Young and a number of other nurses gave their evidence. "I was very much impressed", reported the Judge, "by their businesslike manner, their knowledge of their work, and the favourable appearance they made. I would say they are entirely a credit to the great profession they represent. The same remark applied to Doctor Piercey, Doctor Featherston, and the members of the medical profession who appeared and gave evidence . . . I thought they were entirely fair and unbiased in their opinions, and in the evidence they gave."

With respect to the allegation that the patients were suffering unnecessarily and often getting service far below the minimum standards called for, Judge McDougall found it difficult to define adequate care in the light of what is ideal and what is practicable, but concluded "that the Ottawa Civic Hospital generally is a well conducted and well managed hospital in which the standard of care and treatment given to patients is all that can be reasonably expected by a citizen of Ottawa in this day and age".

He dismissed the charge of negligence for not supplying mother's milk in one case, considering that this was entirely a matter of direction by the attending doctor. Nor have the doctors on the staff asked that a mother's milk bank be established. He found "the closest and most effective co-operation between the medical staff and the hospital authorities and employees".

No Evidence Produced

No evidence was produced concerning some of the charges in the editorials. The newspaper did not consider itself obliged to produce witnesses, although it did produce some. The Judge took the position "that the *Citizen* was a responsible

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Present-Day Trends in
Hospital Administration

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THOSE critics of voluntary hospitals who judge results by a glance at the financial statements might well say that it is high time that there were new trends in hospital administration. Without denying that room does exist for improvement of our present procedures, I would point out to those critics that hospital efficiency and its place in the community have not and never will be rightfully judged on the basis of financial statements alone.

Behind a surplus there may be less than reasonably adequate patient care; behind the red figures of a deficit—all too common and all too large these days—there may be a large amount of unheralded free work to those who cannot afford to pay.

Rather, let the critics judge the hospital on how well it is meeting its fourfold objectives: namely, care of the sick and injured, research, teaching, and community welfare.

We can help them evaluate our activities if we will come out of our shells and tell them what we are trying to do and how little we have with which to do it; what our problems are and how they can be solved not by a few but by the efforts of the community at large.

The financial plight of the voluntary hospitals has brought home to members of governing boards, more forcibly than any other single factor, a much greater appreciation of the role of the hospital in the day to day life of the community. Charged with the responsibility of adequate financing of the hospital, governing boards have been forced to appeal to the community more often and for greater sums. In order to conduct a successful appeal, they must be able to present a good case and to present a good case they must take more than a passing interest in their hospital's activities. Their critical eye in turn stimulates the administrator and through him the department heads, both professional and non-professional, to a greater appreciation of their own responsibilities, coupled with the directive that efficiency, and economy, consistent with good patient care, are the watch words. I must make it perfectly clear that this increased interest on the part of the members of the governing board does not and must not mean their assumption of any administrative duties which are properly the prerogative of the administrator.

Training of Administrators

We are all familiar with the trend of the last few years toward the formal training of hospital administrators. This is a most welcome innovation provided that the candidates are carefully selected and have an adequate amount of on-the-job experience before they assume positions of top level responsibility. I would go a bit further and suggest that candidates serve an apprenticeship period to determine their fitness before they are actually enrolled in the formal training program.

The administrator who is asked to take an administrative resident for further training should do so only if he is prepared to give considerably of his time and efforts on the resident's behalf. Once he has decided to act as preceptor he will find the association to be a most pleasant and beneficial one—provided he has picked the right student and provided the student has picked the right preceptor.

There is need, however, for a training program for those worthy individuals who do not have the qualifications necessary for entrance to the present university courses. I would hope that the day is not too far distant when a course on the undergraduate level can be established. Such a hope must be a reality if we are to meet the needs of the majority of our hospitals.

The extension of the training program to the department head level in the form of institutes is most desirable. I have found that key personnel who have attended have come back refreshed by contacts they have made, encouraged in the knowledge their work compares favourably with others, and stimulated to make a critical survey of their whole department.

Personnel Policies

It is encouraging to note a trend toward more liberal personnel policies. There is no rational basis for the premise that a person who works in a hospital should receive less remuneration simply because he does work in a hospital. We would be on more solid ground if we followed the principle that persons in a community should receive comparable pay for comparable work regardless of the location of that work. Because hospitals must compete with other employers we have found it necessary to increase salaries, to shorten the work week, and to institute group insurance and pension plans.

An address presented at the Annual Meeting of the Maritime Hospital Association, Halifax, N.S., June, 1949.

We are happy to do all of these things within the limits of our resources. Because of a lack of housing accommodation, a greater percentage of personnel now live "out", one result of which has been a trend toward payment of gross salaries and an appreciation, too long delayed, of the real value of perquisites. Living quarters, working conditions, rest rooms, recreational facilities, have all been given more attention, but there is still much to be done here.

Only in vacations, hospitalization, and sick benefits have we been more liberal, as a rule, than many in industry. At times I wonder whether these were not prompted on the one hand by certain qualms as to the salary schedules and on the other by the entirely erroneous impression that it costs nothing to hospitalize one of the staff. Hospital personnel should be no exception to the custom of employees carrying their own Blue Cross either in full or in part.

This liberalization of our personnel policies has necessitated the establishment of personnel departments where none existed and an expansion of those already in operation. Regardless of the size of the hospital, one or more competent individuals should have the responsibility for implementing personnel policies and for supervision of personnel welfare.

An integral part of the personnel department is the personnel health service. Medical attention should be rendered by the admitting officer where possible or by junior members of the attending staff on a part time basis with appropriate remuneration. There is no question of the value of preemployment examination. A chest x-ray examination at periodic intervals is a must. The use of BCG vaccine, where indicated, for nurses and others in contact with the patient should be carefully considered.

Extending Spheres of Activity

Because there is a growing demand that the general hospital be "general" in fact as well as in name, there is a trend in the general hospital to extend its sphere of activity, with a concurrent decrease in the number of specialized hospitals. Most noticeable are the provision of psychiatric facilities, the treatment of alcoholism more recently by "Antabuse", the practice in some areas of adding facilities for communicable diseases, surgical tuberculosis and the chronically ill, all within the domain of the general hospital.

No reference can be made to the care of the chronically ill without mention of the plan for home care which was initiated at Montefiore Hospital in New York City some two years ago and which met with such success that the plan has been adopted in principle by the Health Authorities of New York City and other areas. There is not time to discuss the details of such a plan but I am advised that in Montefiore's experience the home care per diem cost is only twenty-

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Un Résumé

L'Administration de l'Hôpital

Les critiques des hôpitaux volontaires qui jugent les résultats par rapports financiaux pourront bien dire qu'il est temps pour de nouvelles tendances dans l'administration des hôpitaux. On pourrait répondre que derrière un surplus, il y a peut-être un manque de soin suffisant des malades, et que derrière les chiffres rouges d'un déficit—trop commun et large aujourd'hui—il peut y avoir beaucoup de soin, dont on ne dit rien, à ceux qui ne peuvent pas payer. Nous des hôpitaux volontaires sommes bien troublés par notre position financière. Le public est bien généreux quand nous leur demandons de l'argent, mais nous croyons que c'est le gouvernement qui devrait payer pour les indigents. Il devrait payer un prix per diem, et ne pas attendre pour ce prix de l'autorité dans les hôpitaux.

Le cours dans l'administration des hôpitaux est une bonne innovation pourvu que les candidats soient choisis avec soin et travaillent dans les hôpitaux avant de prendre des positions de responsabilité. Je pense qu'il devrait y avoir de plus un temps d'apprentissage avant le cours. On a aussi besoin d'un cours pour les personnes qui méritent le prendre, mais n'ont pas assez d'éducation pour le cours universitaire. Les cours avancés qui sont donnés aux chefs des départements sont de grande valeur. Ceux qui les prennent en reviennent rafraichis et encouragés.

On est content de noter la tendance vers un système plus libéral envers le personnel. On paye plus d'attention aux appartements des employés, aux conditions sous qu'elles ils travaillent, à leurs salles de repos, à leurs facilités de récréation. Quant aux vacances et à l'hospitalization, les hôpitaux sont plus généreux que beaucoup d'industries. Cette libéralization a rendu nécessaire l'établissement d'un département de personnel dans les hôpitaux où il n'y en avait pas, et l'agrandissement de ce département dans les hôpitaux où il était déjà établi. Une partie intégrale de ce département devrait être le service médical des employés. Chaque employé devrait être examiné par le docteur avant de commencer à travailler à l'hôpital, et il devrait avoir des x-rays régulièrement.

Parce qu'il y a plus en plus de demandes que l'hôpital général soit "général" en réalité et non seulement en nom, il y a une tendance aujourd'hui que l'hôpital général étende le cercle de son activité pour comprendre des départements de psychiatrie, de maladies contagieuses, de maladies chroniques, de dentisterie, de médecine physiqûe, de thérapie d'occupation, et de la réhabilitation de ceux qui ont des handicaps.

La tendance vers la spécialization en ce jour rend les différents cours plus longs et plus chers. Alors, au moins que la médecine et les professions alliées vont être réservées pour les riches, on a besoin de beaucoup de bourses. La situation critique des hospitalières est encore sans solution immédiate, mais il n'y a pas beaucoup de doute qu'il va être nécessaire de commencer un cours sur un niveau secondaire. ●

five per cent of the in-patient per diem cost and that only about fifteen per cent of the patients are suitable for such care. In other words, the home care plan is complementary to but cannot supplant special hospital facilities for the chronically ill. It should be added that such facilities should be closely associated with the general hospital both administratively and physically and should not be separated by a long distance which means isolation from the parent unit.

There is a growing appreciation of the very great benefits of a dental department, of physical medicine, and of occupational therapy. Specialized facilities are being provided, but so far too few in number, for the rehabilitation of the handicapped.

The trend toward specialization of doctors, nurses, and others engaged in the hospital field with the accompanying expense of long training has its advantages, but it also poses certain problems which are not easy to solve. If the medical profession and the allied services are not to become reserved only for those with material wealth, funds must be found, to a much greater degree than now exists, for scholarships for those who are able but who lack financial resources. Funds must also be forthcoming for similar purposes for administrators, nurses, technical personnel, and others who are worthy of and who should have additional training and experience, both necessary for anyone who aspires to advancement.

The critical nursing situation is still without an immediate solution. There seems no doubt, however, that there must be vigorous and immediate action to initiate a nation-wide program for the training of a secondary level. It was done during the war and there is no reason why it cannot be done in peace.

An increasing public awareness of the importance of preventing ill health and maintaining good health has, with the help of the Blue Cross and other prepayment plans, contributed largely to the unprecedented demands upon hospital facilities. We are hard

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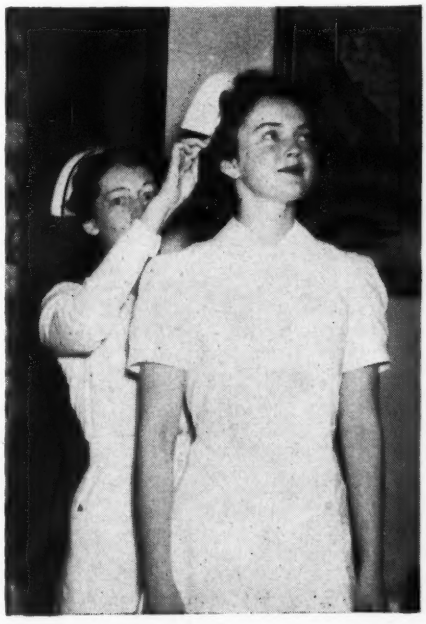
All-White Uniforms at Capping Exercises

WHEN the Toronto General Hospital held its capping exercises on July 22, thirty-two girls, dressed in attractive new white uniforms, and several members of the hospital staff were present at the simple effective ceremony held in the nurses' residence.



As each girl took her place and received her cap, she was congratulated by Miss Mary MacFarland, superintendent of nursing, whose brief remarks at the end voiced her congratulations and encouragement. She pointed out that all of the students had obtained honour standing. It was also noted that a number of the girls had relatives engaged in hospital work and that two were Canadian-born Ukrainians, one a Canadian-born Japanese, and one a Canadian-born Hungarian.

Departing from the standard blue uniform with white aporn, this class wore smart white uniforms with short sleeves and deep inset side pockets, thus doing away with starched cuffs, collars, bibs, and aprons. The all-white uniform is a departure which will establish a precedent at the hospital. Not only is it attractive in appearance, but it is also practical, and should prove very popular.

A Review of Obstetrical Deaths—

During a Ten-Year Period at the Royal Alexandra Hospital, Edmonton

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Edmonton, Alta.

THIS review of obstetrical deaths in the Royal Alexandra Hospital, Edmonton, during the years between 1939 and 1949, is part of a study of this subject covering the entire city for this period. No attempt is made to compare our results with any institution either in this city or elsewhere. It should also be pointed out that any such discussion as this by one individual must of course be coloured by the opinions of that individual. It is to be emphasized then that, in reviewing these cases, the criticisms which will be made are entirely impersonal (two of these women were patients of the Baker Clinic) and that criticisms are made with the hope that we may all learn some facts which will prevent similar fatalities in the future.

While we all realize that deaths of our patients are at times inevitable, I think we should view obstetrical deaths with greater seriousness. By and large pregnancies occur in healthy young women and, in a large percentage of cases, they can be expected to pass through pregnancy and delivery with no complications and no serious sequelae—even without any medical care. It therefore behooves us as modern physicians and surgeons not only to carry these healthy young women safely through pregnancy but we must advise and protect those less fortunate, who suffer from some pre-existing disease, from an untimely end whilst in the process of bearing a child. In other words all obstetrical deaths should be preventable.

Autopsies were performed in two-thirds of the total cases, but even in some of these cases the exact cause of death could not be set forth because of lack of definite findings, or because of the presence of more than one contributing factor. In the other group, without autopsies, the diagnosis could be established with reasonable accuracy.

It should be mentioned here that our records leave much to be desired, although a noticeable improvement is seen as the years pass. One still has to dig hard, however, to get the desired information from a chart—if it is recorded at all.

General Results

During this period of ten years, 1939-1948 (see Figure 1), 18,497 patients were delivered in the hospital with a total of 15 deaths, a rate of 0.81 per 1000 births. This rate, however, might be reduced to 0.70/1000 if we delete two cases transferred from the Beulah Home—one suffering from puerperal sepsis, the other from broncho-pneumonia. The latter was in the second stage of labour on admission and died 1¾ hours after admission. Such a procedure, however, cannot be endorsed, and we must accept as a fatality any case that dies in the hospital. It will be noted that the number of deliveries has increased steadily until 1947 when the total reached 2,664, there being a slight drop in total for 1948. And this, I might point out, has been accomplished under difficult circumstances with no improvement whatever in delivery room accommodation, with only ordinary replacement of delivery tables, and with inadequate anaesthesia equipment. From the figures will be noted the number of deaths each year, and the mortality rate; and it is significant that in the first 5 years the average rate was 1.08/1000, while in the last 5 years it was 0.63/1000.

Fig. 1

Year	Del.	Deaths	Rate/1000	
1939	1431	1	.7	
1940	1404	4	2.84	
1941	1431	–	—	1.08*
1942	1522	1	.65	
1943	1582	2	1.26	
1944	1706	2	1.17	
1945	1869	1	.53	1.63*
1946	2320	1	.43	
1947	2664	1	1.37	
1948	2568	2	.77	
Total	18,497	15	.81	

**These figures indicate the average rate per 1000 for the 1st and 2nd 5-year periods.*

Classification

For the sake of simplicity the deaths were classified into 5 groups.

(1) *Toxaemias*—including all cases showing any or all of the triad of hypertension, proteinuria, and oedema—i.e. eclampsia, hypertension, and chronic nephritis,—2 cases.

(2) *Haemorrhage and Shock* — 2 cases. (Haemorrhage alone, or haemorrhage and shock following obstetric trauma.)

(3) Coincident *cardiac disease* — 3 cases.

(4) *Miscellaneous* Group (one each)
Bronchopneumonia
Iso-immunization to Rh factor
Bowel obstruction
Pulmonary embolus
Anaesthesia
Necrosis of the liver.

(5) *Puerperal Sepsis*—2 cases.

Preventability

Any assessment by an individual may be falacious. Attempt to use terms *non-preventable* and *preventable* in a liberal sense.

Preventable		Non-Preventable	
H & S	2	Cardiacs	3
Tox.	2	Pulm. Emb.	1
Obstr.	1	Transf.	1
Anaes.	1	Pneumonia	1
Sepsis	2	Necrosis	1
	8		7

Preventable indicates in general those cases in which it is felt that adequate and timely medical care might have saved the life of the patient; and in this group are included the two

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Training and Maintaining the Auxiliary Nursing Staff

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AN increasing demand for auxiliary nursing service in our hospitals has arisen in recent years because the number of graduate nurses available is quite inadequate to meet the need. If we could train sufficient nurses to do all the work which has been done by nurses in the past, would it be wise? Some studies reveal that 50 to 60 per cent of the time spent by nurses is on work which could be done quite satisfactorily by others less well trained. This being true, what a wastage of trained personnel! Should we not give careful consideration to a program for auxiliary nursing service in our hospitals?

Ward Aides

The hospital in which I serve employed its first auxiliary worker in 1930. This girl was placed on the paediatric ward and trained by the ward supervisor in such duties as changing and feeding babies and washing bottles. She was given the title of *ward aide*. I feel confident in saying that this particular worker saved almost the time of one nurse. In 1931 ward aides were employed on two adult wards taking over such duties as dusting, care of flowers, and feeding helpless patients. In 1934, the number had grown to four and so it continued until now we have 20 to 25 working on a day shift.

Those assigned to general wards perform such duties as: care of refrigerators, care of drinking tubes, setting, carrying and clearing food trays, feeding helpless patients, preparation of nourishments and washing nourishment dishes, keeping patients' water pitchers filled, care of flowers, dusting and tidying patients' rooms, disinfecting and making up empty beds, cleaning enamelware, and running errands.

In addition to these general ward aides we have several who are doing special types of work.

1. *Clerical ward aides.* Their work consists of transferring information from the admission slip to the headings of charts, recording temperatures, pulse, and respiration on the graphic charts, ruling temperature and report books, filling out bed cards, and answering the telephone.

2. *Admitting Aide.* She is stationed on a ward nearest the admitting office. When patients have registered, she is called to take them to their ward. She stops en route, with those who are able, while a routine diagnostic chest x-ray is taken. Between calls this aide carries on with ward duties.

Illustrations in this article are by Wava McCullough in "Illustrated Handbook of Simple Nursing". By permission of McGraw-Hill Publishing Co. See Review in this issue, page 50.

3. *Messenger Aide.* She makes several trips through the hospital each day, picking up requisitions, returning equipment to other departments, and taking messages.

4. *X-ray Aide.* One who transports patients from wards to the x-ray department.

5. *Physiotherapy Aide.* She is trained to assist the physiotherapist and sits with patients during treatments.

6. *Operating Room Aide.* Cleans instruments, folds linen, keeps doctors' room tidy, and other duties.

7. *Aide* who assists the nurse technician with the checking of oxygen and care of oxygen equipment.

8. *Aide* who is employed in the blood bank.

Most of these aides work from 7 a.m. to 3.30 p.m. You ask who carries on the remainder of the day? We have a group of about twenty-five, mostly high school girls, working from 4.30 p.m. to 6 p.m. These are termed *evening ward aides.* Their duties consist almost entirely of helping serve the suppers and feeding helpless patients.

The ward aide is employed singly as an opening occurs. The nurse in charge of the group spends a greater part of the first two days giving instructions and working with the new ward aide. After this the aide is given definite duties. She works under the ward supervisor, with additional supervision and help from the nurse in charge of auxiliary nursing service. She is paid a salary of $65 a month, with two meals a day, increasing $5 each six months until a maximum of $80 is reached.

Nurses' Aides

In 1946, when the chronic convalescent ward of fifty-three beds was about to be opened, the superintendent of nurses did not know how she was going to staff this department. It was thought that this type of patient could be given adequate care by a less trained person than a registered nurse. To use our student nurses in this capacity, even if we had sufficient, was not being fair. It would not provide enough teaching material.

Thus, the six weeks *nurses' aide*

From a paper presented at the May, 1949, meeting of the O.H.A. Regional Council, Districts 1 and 2.

course came into being. Small groups of girls were given a very intensive six weeks course in approach and attitude to the patient, the housekeeping duties which we always find wherever there are sick people, and the simple nursing procedures that are so necessary and so time-consuming. This course has been repeated four times, making five groups in all, varying in size from four to ten students.

Training Nurses' Aides

About three or four weeks before the course is to open, an advertisement is placed in the local paper. A careful selection of applicants is important. The minimum educational requirement is high school entrance—age, eighteen to forty. The applicant should possess a certain degree of refinement, a neat and clean appearance, good health and a desire to nurse the sick. The length of the course is six weeks, and nurses' aides are taught:

1. Approach and attitude to nursing.
2. Dusting and cleaning.
3. Care of drinking tubes.
4. Care of refrigerator.
5. Care of flowers.
6. Disinfection of beds and cleaning of unit.
7. Making of: closed bed, open bed, anaesthetic bed, ambulance bed.
8. Bed bath including: care of hair, mouth, nails, decubitus.
9. Feeding of patients.
10. Evening care.
11. Hair shampoos.
12. Care of sputum cups.
13. Making of solution for bed pan and hopper brushes.
14. Filling and applying of hot water bottles.
15. Filling ice cap.
16. Giving and removing bed pans and urinals and the care of these same.
17. Making and applying sinapism.
18. Linseed poultice.
19. Antiphlogestine poultice.
20. Fomentation.
21. Taking of temperatures, pulse and respiration, and care of the thermometer tray.
22. Getting the patient out of bed for the first time.
23. Care of the patient during a chill.
24. Enemata and soapsuds — glycerine — molasses.
25. Admitting of patient and care of clothes.
26. Discharging patient.
27. Charting.
28. Care of body after death.
29. Collection of specimens of urine.
30. Simple dressing.

W. McC.

31. Care of rubber gloves.
32. Simple bandaging.
33. Six lectures in anatomy.

Nurses' aides must not give medicines or injections or any major treatments.

Method of teaching: lectures, demonstration by instructress in classroom, return demonstration by the student, and supervised practice on the wards. During the course, test examinations are given. At the completion a written examination in anatomy, one in principles of nursing, and a practical one—a bed bath and complete morning care of the patient—with the superintendent of nurses as examiner.

At the end of the course, the new aides are entertained at tea by their teachers and former graduates of the course. They are made to feel they are part of the hospital family and that they have a very definite and important role in the care of the patient. Now our nurses' aides are ready for full eight hour ward duty, 7.30 a.m. to 4 p.m. For the first few weeks they are given close supervision, guidance and help by the nurse in charge of the auxiliary nursing service.

Where Nurses' Aides Are Valuable

There are two situations in which we find the nurses' aide is valuable.

First is with the chronic convalescent patient. They have sufficient training to give this type of patient the care he needs. In fact I have known occasions when the convalescent preferred the nurses' aide to the nurse because she was able to spend more time with her—in helping her learn to walk, for example.

The second situation is in the more active ward. A carefully chosen general duty graduate nurse and a nurses' aide are given an assignment of patients and work as a team. The graduate assumes the responsibility of the entire assignment. When two are needed to work with a very difficult patient, the nurse has the aide to help her. If a number of patients are at the convalescent stage, the graduate arranges for the nurses' aide to give morning care or make

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Resumé

Les Aides aux Garde-Malades

Il se peut qu'il y a des désavantages dans l'usage d'aides dans l'hospital. Il est vrai que le personnel n'est pas aussi fixe, qu'il y a plus de gaspillage de personnel que dans un groupe plus professionnel et que quelquefois ce gaspillage semble très grand.

Mais il y a aussi beaucoup d'avantages. Ces aides font beaucoup des tâches qui demandent peu d'instruction que les garde-malades étaient obligées de faire dans le passé. Elles donnent aussi les soins routiniers, et ceci donne plus de temps aux infirmières pour les traitements plus techniques qui augmentent tous les jours avec l'agrandissement de la science médicale. Et puis, si le personnel est gaspillé, l'hôpital n'est-il pas supposé d'être le centre de l'éducation sur la santé dans la communauté? Ces personnes qui ne continuent pas à travailler dans les hôpitaux ne seront-elles pas de plus grande valeur à la communauté à cause de l'enseignement qu'elles ont reçu? Elles sont toutes venues à l'hôpital parce qu'elles voulaient soigner les malades. Même chez eux, alors, elles pourront mieux accomplir cette tâche. •

Food and Its Service

Efficiency in the Dietary Department

Sister Agnes Cecelia, M.Sc.,
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THERE was a time when dietary departments and dietitians held a low place in the scale of importance in a hospital. For years, their function in the general administration was not recognized at its true worth. Now nearly every hospital has come to appreciate the role played by the food service department in the general welfare of the institution and, more especially, in the fulfilment of a hospital's primary purpose—*service to the patient.*

If, however, the dietary department is to hold its rightful place and fulfil its purpose, it must be efficient. Do you know how Webster defines this oft used word? "Causally active". Satisfactory service to the individual patient is the one big effect toward which all the efforts of the dietary department must be directed. A department is efficient when its actions bring about this effect.

But how vast is the field that is included in the question: "How can we make our department efficient?" Let us look at this question from seven points of view:

1. What do we consider the *ideal* in service to the patient?
2. What are the administrators' attitudes toward the food service?
3. What is the essential professional staff of a dietary department?
4. What is the ideal set-up and equipment of a department?
5. What type of service is best for each individual hospital?
6. What are the personnel problems?
7. What role does supervision play in this great work?

The Ideal in Service to the Patient

Scientific research in the field of nutrition has proved, beyond any doubt whatsoever, the vital influence food has on a human being. We are all well aware of the preventive aspect of nutritious food. Some of us may need a little reminder of its therapeutic value. A patient in a hospital can usually be considered one who needs food therapy as much as and sometimes more than any other type of therapy. Reports from the world over tell us that in most instances the first thing a patient comments on, when asked about the hospital, is the food. Those of you who have been patients at any time will admit that your tray, with its merits and demerits, looms large in your memory. The psychological aspect of a tray is a topic in itself.

The more the patient is considered a human individual by all concerned, not merely a number, the more advantageous the treatment, both physically and psychologically. Every human being craves attention, and a sick human being proportionately more. The meals served him during his hospital day are points of contact wherein he deservedly looks for personal consideration. True, large hospitals must be institutionalized to cope with the demands, but it is not efficiency to sacrifice ideal service to the patient for the sake of quick and easy methods of routine procedure. No matter what type of service, there must be personal contact by those who know and are interested in the patient's dietary welfare. It may call for more organization and co-operation on the part of the entire hospital staff, but with an ideal before us, can any effort be considered too great?

Administrators' Attitude

In most hospitals now, administrators are keenly interested in and co-operative in the work of the dietary department. But many have yet to be converted! Such administrators must be made to realize the gigantic task of the dietitian and her staff. As to the methods of conversion, I leave that to you. Without this realization, support cannot be obtained, and this can be the beginning of weakness in the department. Friendly but strict and constant supervision from administrators will go a long way toward improving the standards of food preparation and service. Staff doctors, nurses, dietitians, and dietary department personnel are quick to sense the attitude of the administrators and react accordingly.

One practical suggestion which has done much in many places is to have your administrators, doctors, nursing supervisors, in fact any member of the staff, visit the various units of the department while in action. Do not have these visits as official inspections, do not shine up and dress up the kitchen, do not warn the workers. Let those concerned "drop in" during rush hours, service times, or clean-up sessions and see for themselves just what goes on in the department. Lack of understanding often causes many unnecessary difficulties.

Professional Staff of the Department

One of the griefs of hospital boards today is the great difficulty experienced in obtaining qualified

From a paper presented at the Maritime Institute for Administrators, June, 1949.

Good Program Arranged for Western Institute at Regina

Dr. H. E. Baird, Mr. John Smith, and their committee, have now completed arrangements for the Western Canada Institute for Hospital Administrators and Trustees at Regina, October 3 to 8.

A varied program has been prepared, featuring such topics as the problems of small hospitals, fire hazards, the training of auxiliary helpers, personnel problems, trends in nurse education, hospital decorating, hospital insurance, public relations, admitting procedures, the medical staff, the laundry, and others. Outstanding speakers will be present from eastern and western Canada and from the United States.

A feature of this year will be the lengthy discussion periods following each address.

The Saskatchewan Hospital Association will hold a short business meeting on October 8.

dietitians. There is no question about it, dietitians are scarce generally and very scarce in the Maritimes. Efforts to encourage young girls to pursue such a career are met with a veritable flood of objections. A dietitian's job is a hard one, to speak plainly, and it seems that unless the financial remuneration is made more attractive the scarcity of professional members will continue.

Trained dietitians are essential to efficient organization and management of a department. A four-year college course plus a one-year student internship qualifies a dietitian as professional. Experience is the greatest aid to efficiency. Hospitals will be in need of more and more dietitians, for modern planning and up-to-date organization is tending toward the plan of having floor dietitians who handle all dietaries and supervise all outgoing trays on each floor. How this demand is to be met in our provinces is an open question. It is a consideration worthy of note in passing that, as there is no hospital in the Maritimes with a recognized student training course, many of our local home economics graduates go outside for their year's hospital internship and do not return.

In the organization of the hospital, the accepted plan is to give the dietitian sole charge of the entire department, making her responsible to the director of the hospital. Many authorities state that a ratio of one dietitian to one hundred patients is desirable. Others have set the figures at one dietitian for every sixty patients. The organization and plan of service, however, really determines each hospital's need.

Set-Up and Equipment

Experts tell us that the essence of modern architectural planning is simplicity based on function. Simplified building must be preceded by simplified thinking which is dependent upon an understanding of fundamental requirements. The smooth operation of the department is greatly influenced by planning and construction. Careful consideration must be given to space allotments, to ventilation, lighting, types of floors, walls and ceilings, water and steam supply, plumbing and so forth. Thinking must be done in broad terms, considering the problem as a whole.

In new construction, the problem is comparatively simple. Today, general principles are well recognized; architects, consultants, directors, and members of the department, can collaborate to see that these principles are embodied in plans and specifications. May I here strongly urge administrators to let the dietitians who are going to work in the food service department help to plan it? Details which can be known only to those who work in such a set-up make or mar the successful operation of the department.

In hospitals already built, often one or more features may be inadequate or completely lacking; this is a more serious problem. Recognition of essential defects and gradual correction of them is possible with effort and determination. In some cases, it has been greater economy to abolish old kitchens and replace them by modern, well-planned, labour-saving departments.

The total space and the general lay-out must necessarily be scaled to the bed capacity, the type of service, the number and type of dining-rooms and cafeterias for staff members and employees. Stinting space often results in over-crowded work areas which hinder the successful operation of the department. Once the total floor area has been established, the various units, comprising every phase from the receiving of supplies to the disposal of garbage, will be planned in accordance. At the present time, many favour the more horizontal type of structure, which would affect the floor plans of the department very definitely.

A summary of the salient features might include these ideas:

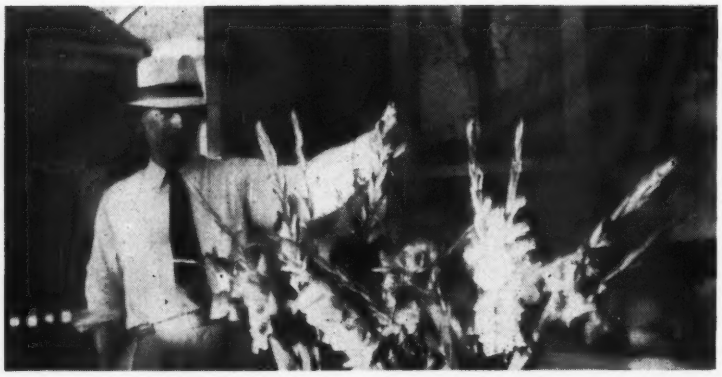
1. **There is a world of thought behind a plan and the dietary department staff members are eminent in that world.**
2. **Work units are co-ordinated parts of a whole; the general over-all result depends on their inter-relation.**
3. **Experienced workers tell us that they have yet to see a hospital kitchen that is too large.**
4. **Increased bed capacity necessitates increased food service capacity, a fact which is often overlooked.**
5. **No effort, time, available money, or sacrifice spent in getting the *best* will go unrewarded, for efficiency in the department will lead to more satisfied patients, better public relations, happier staff, and the joy of a job well done.**

Equipment for the dietary department seems to have reached an all-time high in usefulness, labour-saving, efficiency, ease and safety of operation, and satisfactory life-expectancy. The equipment on the market today is the

(Continued on page 46)

The Hobby Corner

14. Mr. Harold Beesley



HAROLD BEESLEY of the business office at the Regina General Hospital has two hobbies, raising bees and growing gladioli. His flowers have won a number of prizes at local horticultural exhibitions. In the not-very-clear snapshot reproduced here, Mr. Beesley is showing a bouquet of cut blossoms. Unfortunately it is difficult to photograph flowers effectively in black and white. Concerning this hobby, Mr. Beesley has sent us the following explanatory note:

"Having been raised on a mixed farm in the beautiful Saint John River valley in New Brunswick, I believe the touch of the soil still remains with me. Therefore, to combine beauty and pleasure in cultivating the good earth, about eight years ago I took up the growing of gladioli as a hobby.

"I have had great pleasure in this endeavour and, while I have won prizes, my efforts were not made with that in mind. I consider that the beauty produced and the satisfaction found through successful growth to be sufficient recompense for any time devoted to this hobby." •

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product of scientific research and engineering skill. When purchasing equipment for a new department that is being planned, or an old one that is being brought up to standard, four guiding principles might be kept in mind:

(a) Capacity of equipment needed depends upon number to be served, type of service, type of menu, and available labour.

(b) Available floor space determines how much of this and what sizes are to be accommodated to best advantage.

(c) When this has been established, the most workable arrangement of it must be decided upon with a view to the activities of each unit as a part of a co-ordinated whole.

(d) The kind of equipment best calculated to serve the purpose must be purchased.

The kind of equipment is often determined by cost. The best in equipment is expensive, but the total cost of installation must be weighed against the life expectancy, the cost of maintenance and repair, the increase in efficiency expected, and the hours of labour saved. An example might be cited: a galvanized sink is estimated to last five years, whereas one of stainless steel has a life expectancy of thirty-five years.

A last thought might be added: choose equipment that can be easily cleaned and maintained in a sanitary condition. Not infrequently poorly cleaned equipment has been the cause of epidemic food poisonings.

Types of Service

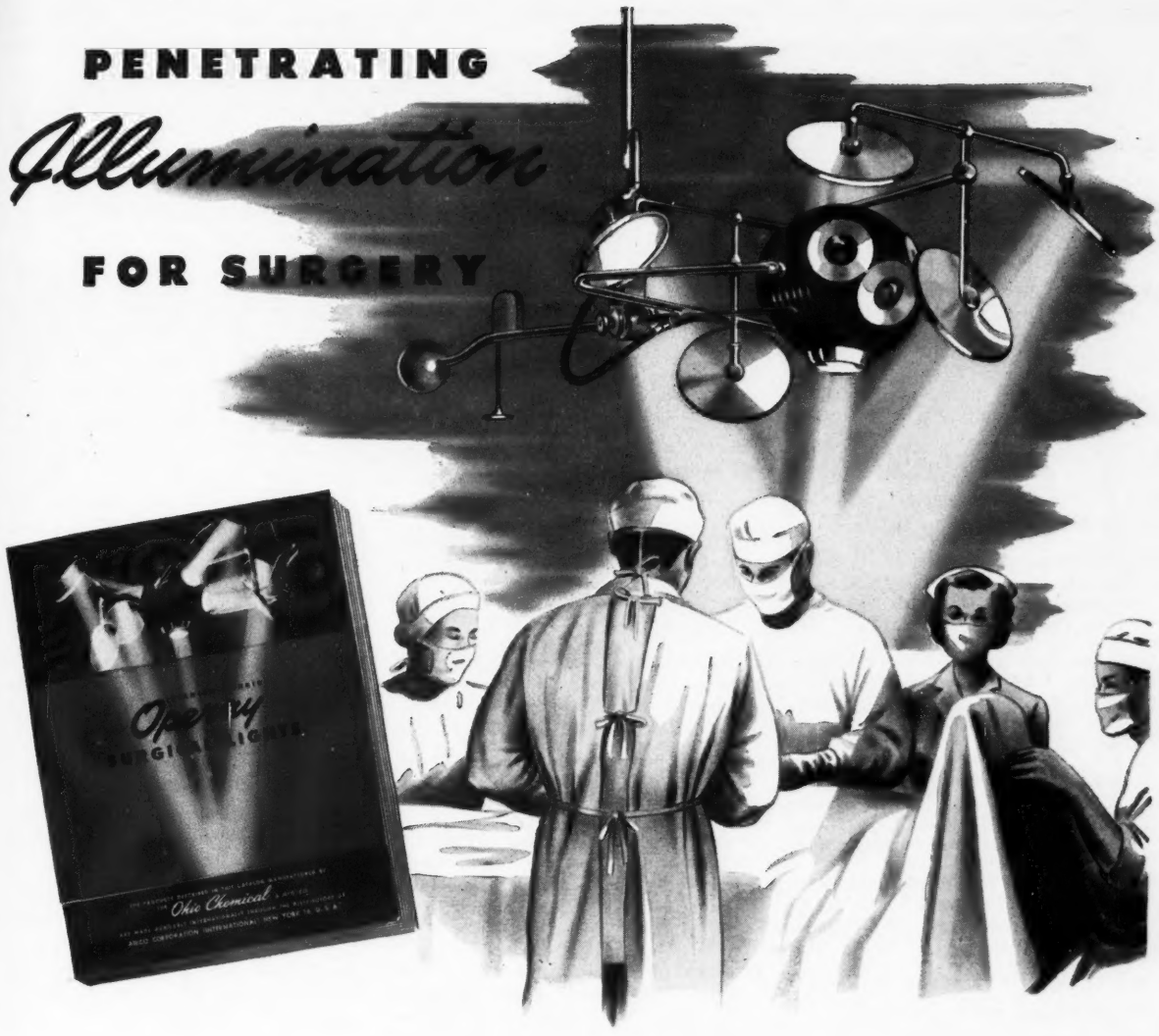
It is well understood that the type of service chosen must fundamentally depend upon the set-up of the hospital and the number to be served. There are basically two types of service, centralized and decentralized, and of these two basic types there are many variations.

Large hospitals will undoubtedly require some form of centralized service to facilitate feeding great numbers. The time element is of major importance and time-saving is great in a centralized system. Control of food is better, for amounts prepared and used can be better regulated and "left-overs" are not being returned to the main kitchen from several unit serveries. Fewer general workers are necessary, for one serving staff does the entire job. Obviously, too, not as many professional workers are needed. Chefs' and bakers' tasks are simplified, for often in such a system choice of foods by the patients is curtailed. A dietitian checks every tray as it leaves the central unit; therefore supervision of each patient's dietary is considered possible. More bed space is left available on the floors because there is no need of floor kitchens. Cost of equipment is lowered as there is no need of duplicate services. Pilfering of food by staff and employees is eliminated. Food odours, noise of preparation, and dish-washing, are kept away from the patients.

Counter arguments may be advanced. Food can be controlled likewise in a decentralized system where the dietitian demands careful ordering and usage on the part of those responsible for the serving of trays in the unit. Perhaps more workers are needed for a decentralized system but the dividends on the investment are great. There is a question, really, as to how many more are needed. In a decentralized service, the nurses

(Concluded on page 76)

PENETRATING *Illumination* FOR SURGERY



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Library Service

THE following is a partial list of publications which are available on loan for a period of three weeks from the library of the Canadian Hospital Council. A further list of books and manuals dealing with these and other departments of hospital and health services will be supplied in future issues of this Journal, and additions to the library will be brought to the attention of our readers from time to time.

THE HOSPITAL IN CONTEMPORARY LIFE. Pp. 288. 1949. Edited by Nathaniel W. Faxon, M.D. Harvard University Press, Cambridge, Mass.

HOSPITAL TRENDS AND DEVELOPMENTS. Pp. 819. 1948. Edited by A. C. Bachmeyer, M.D. and Gerhard Hartman, Ph.D. Commonwealth Fund, New York 22, N.Y.

HOSPITAL CARE IN THE UNITED STATES. Pp. 631. 1947. A Report of the Commission on Hospital Care. Commonwealth Fund, New York 22, N.Y.

THE HOSPITAL IN MODERN SOCIETY. Pp. 768. 1943. Edited by A. C. Bachmeyer, M.D., and Gerhard Hartman, Ph.D. Commonwealth Fund, New York 22, N.Y.

Planning and Construction

THE MODERN SMALL HOSPITAL and Community Health Centre. Pp. 138. 1946. This publication contains interesting floor plans and general data relative to 40-bed hospitals with provision for expansion to 60 beds. Modern Hospital Publishing Company, Chicago, Ill.

ELEMENTS OF THE GENERAL HOSPITAL. Pp. 46. 1946. A booklet of floor plans of the various departments and services with general notes on hospital planning and area charts for acute general hospitals. United States Public Health Service. F. W. Dodge Corp., New York, N.Y.

HOSPITALS. Pp. 26. 1946. A building types study. United States Public Health Service.

PUBLIC HEALTH CENTRES. 1946. Plans and descriptions of three types of health centres. United States Public Health Service.

PLANS FOR CANADA'S RURAL HEALTH. Pp. 19. 1947. Basic floor plans and equipment lists for 6- and 8-bed health centres and 20-30 and 30-60-bed hospitals. Compiled by H. Gordon Hughes, Chief, Hospital Design Division, Dept. of National Health and Welfare.

HOSPITAL PLANNING. Pp. 232. 1946. Floor plans and general data re the various departments and services. Butler and Erdman. F. W. Dodge Corp., New York.

INSTITUTE ON HOSPITAL PLANNING, A Transcript. Pp. 247. The American Hospital Association, Chicago, Ill.

Administration

HOSPITAL ORGANIZATION and Management. Pp. 944. Second Edition. 1946. Malcolm T. MacEachern, M.D. Physicians Record Co., Chicago 5, Ill.

BUSINESS ORGANIZATION and Management. Pp. 536. Revision 1948. Petersen and Plowmen. Richard D. Irwin, Inc., Chicago, Ill.

BUSINESS ORGANIZATION, Principles of. Pp. 564. 1946. Wm. R. Spriegel. Prentice-Hall, Inc., New York.

SECRETARIAL PRACTICE and Office Administration. Pp. 204. 1947. Capt. J. E. Stone. Faber and Faber, Ltd., London, Eng.

Personnel

PERSONNEL MANAGEMENT. Pp. 589. Third Edition, 1941. Scott, Clouthier, Mathewson and Spriegel. McGraw-Hill Book Co., New York.

JOB EVALUATION AND RATE PLAN for Professional and Non-Professional Employees. Pp. 146. Developed by the Eastbay Hospital Conference, Oakland, Cal. American Hospital Association, Chicago, Ill.

JOB SPECIFICATIONS for a Hospital Organization. Pp. 97. 1940. American Hospital Association, Chicago, Ill.

MANUAL FOR TRAINING Hospital Employees. Pp. 105. Revision 1948. Cleveland Hospital Council, Cleveland, Ohio.

HOSPITAL PERSONNEL MANAGEMENT, Transactions of the First Institute on. Pp. 206. 1944. American Hospital Association, Chicago, Ill.

IN-SERVICE TRAINING and Employee Representation, Institute Transactions. Pp. 226. 1945. American Hospital Association, Chicago, Ill.

STAFFING THE GENERAL HOSPITAL. 25 to 100 beds. Pp. 20. 1949. Staffing guide by departments with the nursing staff on a work week of 40 hours, 44 hours, and 48 hours. Division of Medical and Hospital Resources, United States Public Health Service.

Medical Records

MEDICAL RECORD LIBRARIANS, Manual for. Pp. 308. 1948. Edna K. Huffman. Physicians Record Co., Chicago, Ill.

MEDICAL RECORDS ADMINISTRATION. Pp. 267. 1948. American Hospital Association, Chicago, Ill.

MEDICAL RECORDS IN THE HOSPITAL. Pp. 374. 1937. Malcolm T. MacEachern, M.D. Physicians Record Co., Chicago, Ill.

Legal Aspects

LAW AND THE PRACTICE OF MEDICINE. Pp. 68. 1947. K. G. Gray, M.D., K.C. Ryerson Press, Toronto.

LAW OF HOSPITAL, PHYSICIAN AND PATIENT. Pp. 647. 1947. Hayt and Hayt. Hospital Textbook Co., New York.

LEGAL ASPECTS OF HOSPITAL PRACTICES. Pp. 239. 1938. Hayt and Hayt. Hospital Textbook Co., New York.

LAW RELATING TO HOSPITALS and Kindred Institutions. Pp. 399. 1947. S. R. Speller. H. K. Lewis and Co., London, Eng.

Miscellaneous

MEDICAL STAFF IN THE HOSPITAL. Pp. 288. 1939. T. R. Ponton, M.D. Physicians Record Co., Chicago, Ill.

HOSPITAL PUBLIC RELATIONS. Pp. 361. 1939. Alden B. Mills. Physicians Record Co., Chicago, Ill.

PURCHASING FOR HOSPITALS. Pp. 93. 1947. Walter N. Lacy. Physicians Record Co., Chicago, Ill.

GOVERNING BOARD OF THE HOSPITAL. Pp. 29. 1945. American Hospital Association, Chicago, Ill.

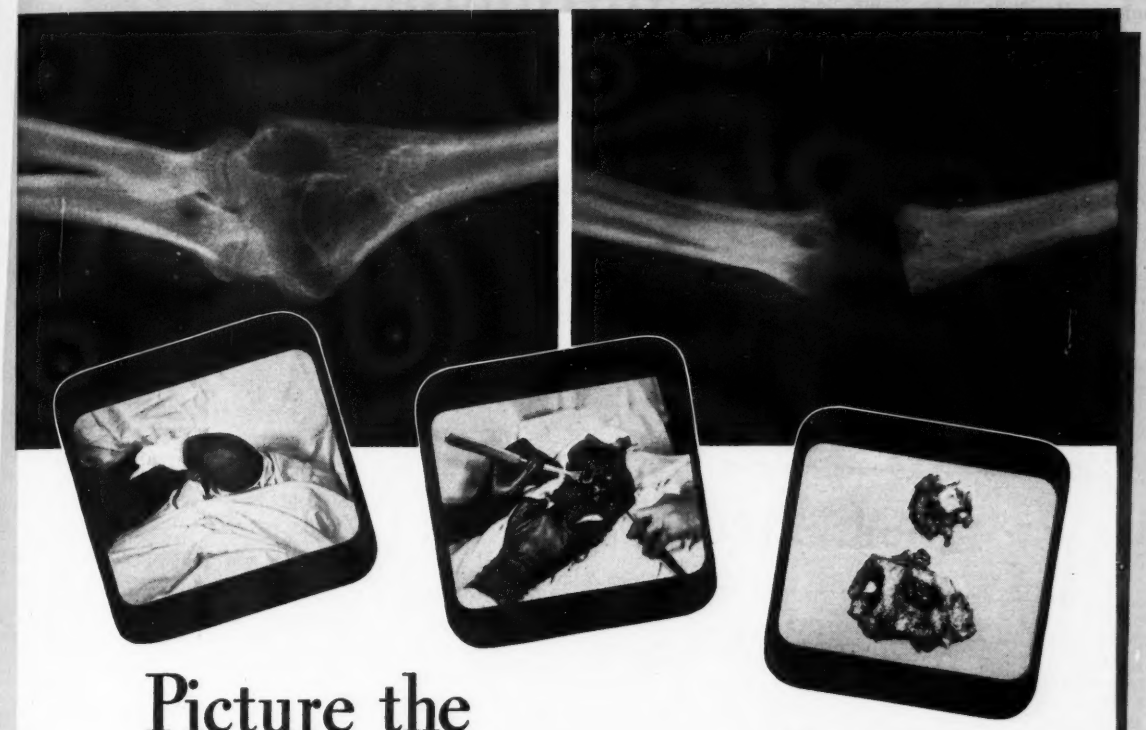
THE HOSPITAL GOVERNING BOARD. Pp. 55. 1949. J. Dewey Lutes. Tidwell Printing Supply Co., Augusta, Ga.

EQUIPMENT AND SUPPLY LISTS. Pp. 84. 1948. For 50, 100 and 200-bed general hospitals. Division of Hospital Facilities, U.S. Public Health Service.

MANUAL ON OBSTETRIC PRACTICE in Hospitals. Pp. 96. 1940. Malcolm T. MacEachern, M.D. American Hospital Association, Chicago, Ill.

MANAGEMENT OF TUBERCULOSIS in General Hospitals. Pp. 47. 1946. American Hospital Association, Chicago, Ill.

MANUAL ON DENTAL CARE AND Dental Internships in Hospitals. Pp. 88. 1941. Prepared by the Committee on Hospital Dental Service of the American Dental Association. American Hospital Association, Chicago, Ill.



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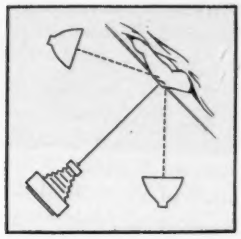

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HOSPITAL DENTAL SERVICE Required of Approved Hospitals, Basic Standards of. Pp. 7. 1948. Prepared by the Committee on Hospital Dental Service of the American Dental Association. American Hospital Association, Chicago, Ill.

CARE OF THE PSYCHIATRIC PATIENT in General Hospitals. Pp. 79. 1940. Franklin G. Ebaugh, M.D. American Hospital Association, Chicago, Ill.

REHABILITATION OF THE PATIENT. Pp. 112. 1948. Caroline H. Elledge. J. B. Lippincott Co., Montreal, Que.

HOSPITAL ETHICS. Pp. 12. 1941. A Code adopted by the American Hospital Association and by the American College of Hospital Administrators. Bulletin No. 42 of the Canadian Hospital Council.

ETHICAL AND RELIGIOUS DIRECTIVES for Catholic Hospitals. Pp. 11. 1949. Catholic Hospital Association of the United States and Canada, St. Louis, Mo.

MEDICO-MORAL PROBLEMS. Pp. 56. 1948. Gerald Kelly, S.J. Catholic Hospital Association of the United States and Canada, St. Louis, Mo.

CODE OF ETHICS. Pp. 15. Revision 1939. Canadian Medical Association.

ETHICS OF ECTOPIC OPERATIONS. Pp. 191. 1933. T. Lincoln Bouscaren, S.J. Loyola University Press, Chicago, Ill.

Book Reviews

PHYSICAL THERAPY, Essentials of a Hospital Department. Published by the American Hospital Association, Chicago, Illinois. 1949. Pp. 37. Illustrated. Price $1.50 (U.S.A.).

This manual has been published by the American Hospital Association in response to the many requests for assistance received from hospitals. It was prepared under the guidance of members of a joint committee representing the American Hospital Association, the Council of Physical Medicine, American Medical Association, and the American Physical Therapy Association. Compilation of the material was made possible by a grant from the National Foundation for Infantile Paralysis to the American Physical Therapy Association. The manual is designed to supply broad guidance in planning, installing, equipping, and administering a physical therapy department in a hospital. It contains suggestions on space allocation, treatment booths, exercise, and hydrotherapy rooms. It lists the equipment required, and gives floor plans for the physical therapy suites in 50-bed, 100-bed, and 200-bed hospitals.

The suggestions and guides contained in the manual apply to problems that all hospitals are likely to face in providing a physical therapy service and should prove very helpful to those planning such a department. Copies may be obtained from the American Hospital Association, 18 East Division Street, Chicago, and are available on loan through the Canadian Hospital Council library.

ILLUSTRATED HANDBOOK OF SIMPLE NURSING. By Wava McCullough assisted by Marjorie Moffit, R.N. Pp. 239. Price $3.50. Published by McGraw-Hill Company, New York and Toronto. 1949.

Nursing aides, nursing students, and those engaged in practical nursing in the home will be interested in the author's unusual presentation of the basic procedures of simple nursing in the home or hospital. The eye-catching black and white drawings on each page cleverly and clearly illustrate the techniques of daily routine care. Step-by-step instructions are given for patient comfort, keeping accurate records and charts, giving medicine, bed-making, patient hygiene, care of post-operative cases, and the convalescent patient, et cetera.

The novel presentation of the material in this book, with its humorous drawings, makes it easily understood and readily remembered. Elementary procedures are clearly outlined and lists of equipment needed for each routine are set out. For the practical nurse who may be doing nursing in the home there are a number of useful hints on what to use in place of standard equipment such as back rests, bed tables, restraints, and sterilizers. Care of children is also graphically presented.

This book might well be recommended to persons in the home who are assisting during a family illness or looking after a convalescent. It might also serve as a valuable review for those who have had previous training.

GYNECOLOGY AND GYNECOLOGIC NURSING. By Norman F. Miller, M.D. and Betty Hyde, Reg.N. Pp. 485. Illustrated. Price $4.50. Published by W. B. Saunders Co., Philadelphia; Canadian Agents: McAinsh and Co. Ltd., Toronto. 1949.

This textbook, appearing in its second edition, aims at combining for the student nurse the lessons and knowledge she might gain from three sources: didactic lectures, practical instruction and training, and extra-curricular reading.

In preparing the text, the authors have attempted to create a clear understanding and give an intelligible description of disease. Carefully prepared pen and ink drawings are liberally used to enhance understanding and to portray specific conditions or procedures. The steps in gynaecologic nursing procedures are also presented in a manner designed to make the reason for, as well as each step in the procedure, clearly understandable and easy to follow.

Such subjects are discussed as anatomy and physiology, psychologic aspects of gynaecology, functional and mechanical disturbances, pelvic infections, benign tumours, malignant tumours of the vulva, vagina and uterus, tumours of the ovary, pregnancy as a gynaecologic complication, irradiation in gynaecology, and gynaecologic nursing procedures.

Toronto Nurse Accepts Windsor Position

Miss Laura Mary Lambe, director of nursing at Women's College Hospital, Toronto, has accepted the position of nursing superintendent at Metropolitan General Hospital, Windsor, Ont. She assumes her duties at Windsor this month.

Notes on Federal Grants

Cancer

The federal government has allotted more than $40,000 to assist Nova Scotia in developing cancer services. The sum of $30,000 has been given to the Victoria General Hospital to help meet the hospitalization costs of cancer patients. More than $10,000 has been allocated to help maintain a cancer tissue service in the provincial division of laboratories. Federal aid will be used to purchase supplies and to pay the salaries of eight full-time technicians, a part-time pathologist and two part-time assistant pathologists.

A cancer control grant has been made to the Moncton City Hospital for the purchase of additional surgical equipment. This hospital is one of the proposed cancer treatment centres for the province of New Brunswick.

Federal funds have been set aside to meet the salary of an assistant pathologist for the provincial laboratory in Newfoundland. He will assist in the scientific diagnosis of surgical material with particular reference to cancer. A second part-time radiologist has been engaged. He will be attached to the General Hospital in St. John's but will serve the whole province for advanced x-ray work.

Construction

Grants for Quebec amounting to $126,000 have been approved by the Dominion government. The Pontiac Community Hospital, Shawville, a new 57-bed institution, will receive $27,000. A grant of $70,000 has been authorized for the Notre Dame de Charny Hospital, Charny, which has a capacity of 70 beds. The Hotel Dieu de Levis has been granted $29,000 toward the cost of adding a floor to the present building. The addition will contain 29 beds.

In Manitoba, the federal government has approved hospital construction grants which will provide 96 beds and a new health centre. The new 46-bed Carman District Hospital has received a grant of more than $46,000. Over $8,300 has been set aside to help meet construction costs of the health centre at Dauphin. It has no beds, but serves as a centre for local health services, including well-baby clinics, x-rays, dental clinics, and immunization programs. The new 12-bed De Salaberry Municipal Hospital at St. Pierre will receive approximately $12,000. In Winnipeg, the Misericordia Hospital has been awarded $27,000 to assist in financing additions and alterations to add 27 beds to the present capacity.

Grants totalling more than $404,000 will help finance additions to hospitals in Ontario. St. Joseph's Hospital, Guelph, which is being enlarged by 39 beds, received more than $39,300; Toronto Western Hospital, contemplating a 197-bed addition, $197,000; St. Joseph's Hospital, Toronto, where a 265-bed addition will be completed this fall, $155,000; and the Alexandra Marine and General Hospital, Goderich, adding 20 beds to its present accommodation, $12,400.

Crippled Children

The federal government has allocated more than $3,700 to finance a crippled children's registry in British Columbia. The registry will be in charge of a qualified nurse who will classify and analyze crippled children's records. On the basis of information obtained a more comprehensive treatment program may be worked out. A grant of $8,000 was made to the Queen Alexandra Solarium for Crippled Children to purchase new laboratory, x-ray, and dental equipment, and an electrocardiograph.

Mental Health

The federal government has made grants of more than $81,500 for a group of mental health projects in Saskatchewan. One project is for the provision of 5 teacher-psychologists, experienced teachers who have had a year's special training at the University of Toronto. These teachers will act as liaison officers between schools and mental health clinics. Another project is for the employment of two clinical instructresses at the mental hospitals as Weyburn and North Battleford to teach the nurse-attendant student personnel actual ward practices.

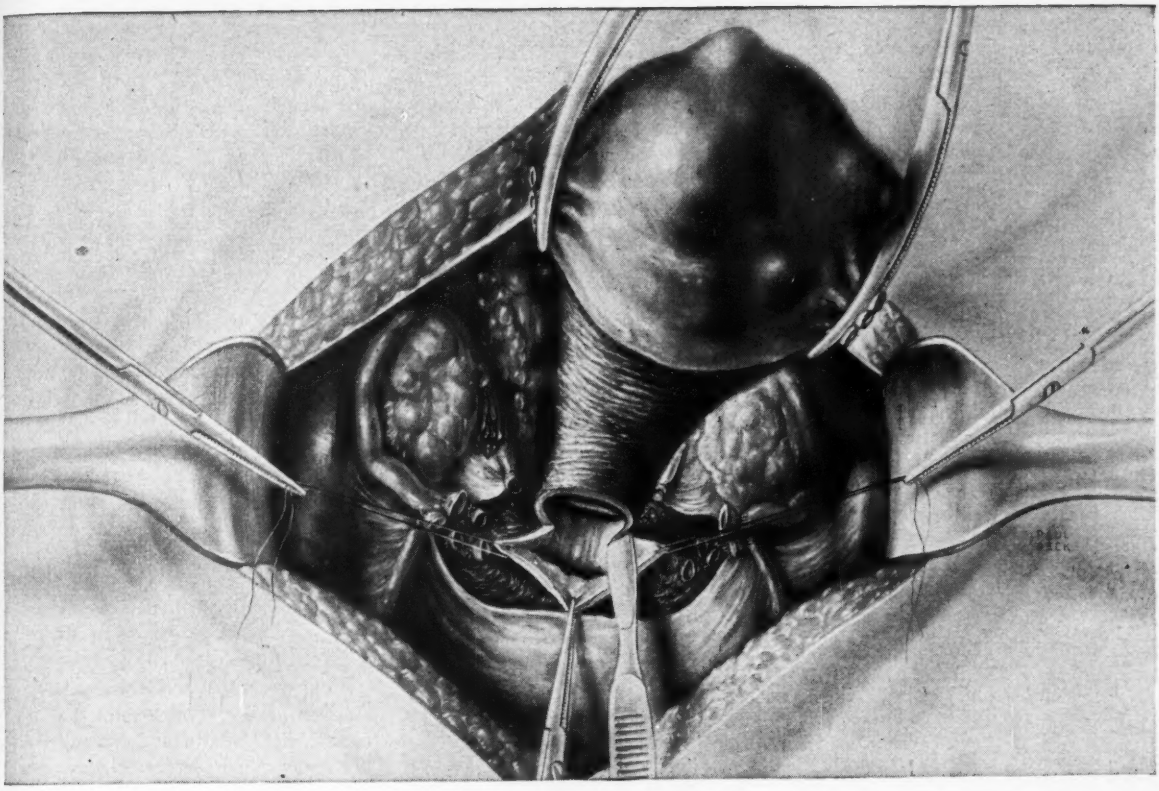
Money has also been set aside to pay the salaries of two occupational therapists and two recreational therapists, as well as to buy occupational therapy equipment for the Weyburn hospital. Two psychologists will be employed in connection with the psychiatric service to correctional institutions in the province. Funds have been set aside to meet the salary of an occupational therapist at the Saskatchewan Training School, Weyburn, to buy new recreational and social therapy equipment for the institution, and to engage a psychologist, who will assist the staff in the classification of patients and the outlining of training suitable for them.

Federal funds totalling more than $23,800 have been earmarked for the salaries of 14 additional workers for the Saskatchewan Hospital, North Battleford. They will staff a new building, housing 60 patients. About $3,000 has been allotted to buy equipment for the mental health clinic in Saskatoon and to permit its director to study practices in outstanding mental health clinics in the United States.

Funds have also been set aside to pay the salary of a full-time director of the Regina mental health clinic. Money has been allocated to assist two teachers to take a year's training in mental hygiene at the University of Toronto; to permit the clinical director of the Saskatchewan Hospital at Weyburn to take a year's postgraduate training in psychosomatic medicine, child psychiatry, and psychotherapy; to enable the director of Regina's mental health clinic to study clinical practices in the eastern United States and Canada; to enable the provincial commissioner of mental services to attend an institute on hospital administration in Philadelphia.

Public Health

A grant of $15,700 has been approved to pay the salaries of four additional public health nurses and two more sanitary inspectors for the Simcoe County Health Unit in Ontario. The increase in public health nurses will permit the extension of public health services, now being



Advances in Ob. and Gyn. Suturing

NEW CLINICAL PROCEDURES FAVOR NEEDLE SUTURES

Sutures swaged to eyeless needles are being more widely adopted for use in delicate tissues by Gynecologists. To meet this trend, Ethicon has developed a new group of 13 Ob. & Gyn. eyeless Atraloc needle sutures. There are 4 new needles, swaged to chromic gut, sizes 3-0 to 2.

The Atraloc eyeless needle draws a single strand of suture through the tissues, eliminating confusion and minimizing trauma. All Ethicon Ob. & Gyn. eyeless needles are swaged to Ethicon's Tru-gauged, Tru-chromicized surgical gut, noted for superior strength and flexibility.

Ethicon sutures with swaged needles are supplied to hospitals at no extra cost over Standard Tubes. They are delivered in the new, unbreakable metal Sterile Pack canisters which guarantee sterility of tube exteriors.

CONVENTIONAL SWAGE

ETHICON SEAMLESS SWAGE

ETHICON Sutures

Johnson & Johnson LIMITED MONTREAL

given in the public schools, to secondary schools in the area. Federal funds have been earmarked for the salary of one additional public health nurse for the Elgin - St. Thomas Health Unit to expand services.

Personnel

With the aid of federal health grants eight persons in Newfoundland are to receive training in x-ray and laboratory techniques. They will take a four months' course at the provincial laboratory, St. John's General Hospital, and the tuberculosis dispensary. On completion of their course, the technicians will work in cottage hospitals in remote districts where they will assist the medical officers. The federal grants will not only meet the cost of their training but also the salaries of the eight persons selected.

More than $35,600 has been set aside from federal grants to assist personnel in B.C. to improve their training in various phases of public health. Funds have been allocated to permit a doctor from the provincial mental hospital at Essondale to take a three-months' course in pathology at the University of Toronto, while a second doctor from the hospital will take a year's post-graduate training in psychiatry at the Allen Memorial Institute in Montreal, and a third will spend six weeks at the Johns Hopkins Hospital studying mental hygiene practices.

Grants have been authorized to assist two staff members of the Health Centre for Children and the Provincial Child Guidance Clinic to take post-graduate training in medical social work and in psychiatric social work respectively at Smith College in Northampton, Mass.; to enable a nurse from the V.D. control division to complete her studies at the University of British Columbia and the University of Washington for a B.Sc. in nursing; to permit two nurses to take post-graduate work in public health nursing and in clinical supervision at the University of British Columbia and the University of Toronto; and to enable two other nurses to take two-months' special training in the care of premature infants.

Bursaries have been granted to enable a health educator to take post-graduate training in health education at the University of North Carolina; to enable three men to take courses in hospital administration at the University of Toronto and the University of Minnesota; to enable a senior instructor in dietetics to take a course in home economics education at the Drexel Institute of Technology, Philadelphia. A total of $10,000 has been allocated to permit staff members of the provincial division of tuberculosis control and the mental hospital services to take short post-graduate courses.

Funds from the national health grants have been allotted to enable 22 persons in Alberta to improve their training. Of the 16 nurses to take this post-graduate training, one will spend six months in paediatric nursing at the Children's Memorial in Montreal; two will study operating room techniques; two will spend several months studying obstetrical nursing at the Margaret Hague Maternity Centre in Jersey City; three nurses will enroll in the McGill School for Graduate Nurses in Montreal, where one will specialize in public health nursing, one in teaching and supervision of nurses, and one in the supervision of psychiatric nursing; one nurse will take the public health nursing course at the University of Toronto, while seven will enroll at the University of Alberta where four will specialize in public health nursing and three in teaching and supervision of nurses.

Federal aid has been allotted to enable a technician to take a short course in x-ray and laboratory work and to assist a bacteriologist studying at McGill University.

Four doctors received bursaries for further studies. One attended a short course in Philadelphia arranged by the American Psychiatric Association for medical superintendents of mental hospitals; a second is spending a month visiting outstanding cancer clinics in Europe and the United Kingdom; a third spent a month at Cornell University studying the diagnosis of cancer by the smear technique; and the fourth will enroll at the University of Toronto for a year's study in public health. The estimated cost of these projects is $15,000.

Research

Three research projects are being carried on in the province of Quebec with the aid of public health research grants. At the University of Montreal, scientists are comparing the thiamin content of potatoes grown in different types of soil. In the department of biochemistry at McGill University, they are studying the effect of diet on the retention and absorption of silicon and zinc in animals and in the human body. The investigation at Macdonald College involves a study of the amount of usable energy obtainable from foods, information on the sources of energy within foods, the effect of the species of animal on the energy-yielding properties of food, and data on the question of the fuel

(Concluded on page 98)

Honoured

Dr. E. A. Petrie

Dr. E. A. Petrie of Saint John, N.B., has been presented with an honorary life membership in the Canadian Society of Radiological Technicians, in recognition of outstanding services to that society. As chairman of its examining board for the past several years, Dr. Petrie has evaluated the qualifications of x-ray technicians across Canada who sought registration with the C.S.R.T. His interest in improved training facilities for technicians has been greatly appreciated.

Radiologist at St. Joseph's Hospital in Saint John, Dr. Petrie also acts as consultant for the Provincial Hospital, Lancaster D.V.A. Hospital, and King's County Memorial Hospital. He is vice-president of the Canadian Association of Radiologists.

Co-operation of Hospitals Urged in Placement of Interns

LATE in August the Canadian Intern Placement Service (C.I.P.S.), a division of the Canadian Association of Medical Students and Interns (C.A.M.S.I.), wrote again to the hospitals approved or commended for internship (by the Canadian Medical Association) urging their co-operation in the placement of interns for the 1950-1951 appointments. Interns for that period will be appointed this autumn and, as definite closing dates have been set for the different stages of the procedures, it is important that this schedule be followed.

The arrangement, which has been approved by both the Canadian Hospital Council and the Canadian Medical Association, will be applicable to students from McGill, Queens, Alberta, Toronto, and the University of Western Ontario. It is not applicable to students from other medical schools where an undergraduate internship worked out in conjunction with the medical school prevails.

All listed hospitals will have received copies of the C.I.P.S. procedure and we presume that it is available to others on request. Students will be asked to apply to the various hospitals of their choice at the beginning of the term. A list of the hospitals to which they have made application, listed in the order of preference, is to be forwarded to the C.I.P.S. office before October 15th. Meanwhile the hospitals are being asked to list the applicants as first choice, alternate choice, or not suitable. To be considered, these lists must reach the C.I.P.S. not later than November 5th. The listings from the hospitals and from the students will then be gone over by a small, impartial committee headed by Dr. A. D. Kelly, assistant secretary of the Canadian Medical Association. The student will receive his first choice if acceptable to that hospital; otherwise he will be appointed to the hospital highest on his list which accepts him. Notification to hospitals and students will be sent out November 15th.

This arrangement should give the highest possible satisfactory results to both hospitals and students. Hospitals will be saved the confusion and uncertainties associated with the old haphazard method of making agreements and having them broken later on. In the case of McGill students there may be some slight modification of the arrangements, applicable mainly to hospitals in Montreal.

As there will probably be unfilled vacancies (the demand considerably exceeds the supply) and as there may be some unplaced students, hospitals with incomplete quotas will be furnished with a list of unplaced students and unplaced students will receive lists of hospitals with vacancies.

The date of November 15th has been selected to coincide with the American date to facilitate possible exchange across the border.

The secretary-treasurer of the C.I.P.S. is Mr. Fred L. Moffat and all correspondence should be sent to the C.M.A. office, 135 St. Clair Ave. West, Toronto. Mr. D. P. Swartz of London, Ontario, is secretary of the C.A.M.S.I.

To Urge Registration of Technicians— C.S.L.T. President Will Visit Hospitals

Starting early in November, Miss Ileen Kemp, President of the Canadian Society of Laboratory Technologists, will visit larger towns and cities in western Canada for the purpose of encouraging hospital laboratory technicians to become members of that Society —which is the official registry of technicians in Canada.

While her plans are still tentative, Miss Kemp plans to hold meetings in Vancouver, Victoria, Lethbridge, Medicine Hat, Calgary, Edmonton, North Battleford, Prince Albert, Saskatoon, Regina, Yorkton, Brandon, Winnipeg, Port Arthur, Fort William, Sudbury, and possibly other centres. Notices will appear in local papers previous to her arrival.

Ileen Kemp

All laboratory technicians will be welcome at these meetings that they may become acquainted with the purposes and aims of the Society. While no official change is being made in present requirements for registration with the C.S.L.T., it is the intention of the examining board to consider each and every application individually and to grant registration to the applicant upon the individual's merits and recommendations, subject of course, to passing the examinations.

Hospital superintendents, pathologists, and other members of the medical profession are asked to co-operate with the C.S.L.T. in this effort to standardize the qualifications and training of laboratory technicians and thus raise the general level of work done in hospital laboratories across Canada. It is hoped that hospital executives will aid in urging all technicians who are still unregistered to make application for registration. Enquiries should be addressed to the Registrar, C.S.L.T., 294 Barton Street, Hamilton, Ont.

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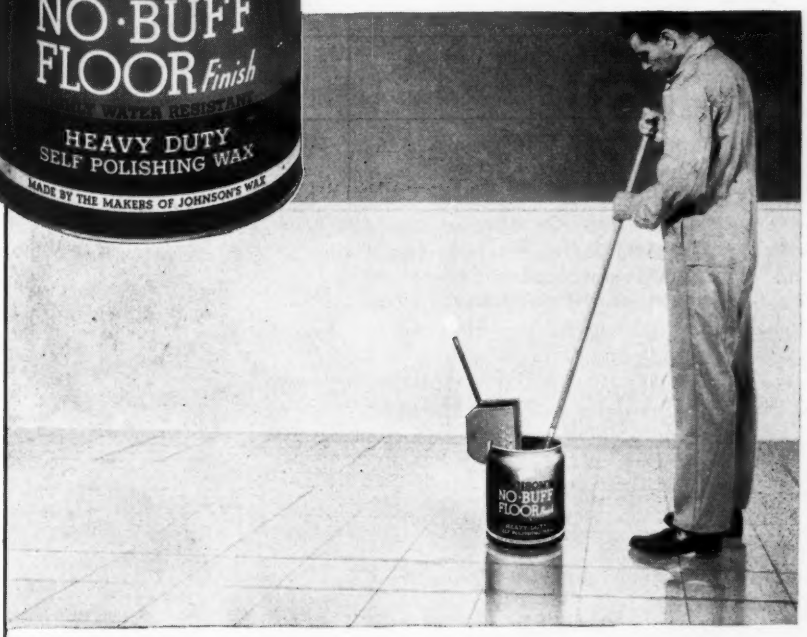

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With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Dear Mr. Editor:

The new national health service has been subjected to so much misrepresentation in Canada and elsewhere that it is desirable to draw attention to a straight forward statement issued by the Ministry of Health for circulation overseas as well as at home. In view of the blind prejudice with which anything emanating from the Ministry is received by some people, it might perhaps have been better if the Ministry had invited an independent research body such as the P.E.P. to prepare this statement. Any publication of this kind is bound to possess the inevitable official bias. Without attempting a summary, it is worth while to look at some of the salient points.

One of the opening statements is that the service has been launched "with remarkable smoothness". This puzzles people in view of the extent of controversy created by the medical profession which, mainly for political reasons, received an exaggerated amount of attention from the Press. But people actually engaged in the Service are in general agreement that it has made a start with much less trouble and friction than they anticipated when the Act came into operation. Everyone knew that many changes were necessary and that the absorption of a large number of self-conscious voluntary hospitals in a co-ordinated plan would involve a good deal of restraint to which they were unaccustomed.

One cause of a good deal of confusion in the public mind was that the health services came into operation at the same time as the new national insurance and national assistance. The insurance is compulsory, so people got it into their heads that the health service was also but, as the brochure points out, "members of the public can use the Service or not, as they wish". The very real obstacle presented by the prospect of doctors' bills need no longer exist for the sick man. This fact may contribute to the aim of the service to be preventive. The report justly observes that "the present expenditure can be justified only on the basis that the essential aim of the Service, and all who work in it, must be to *prevent* illness". It is estimated that the loss of production through sickness leading to absenteeism costs the country at least £300,000,000 a year. This figure does not include reduction of working capacity due to poor health and bad eyesight. Even if Marshall aid is paying for free spectacles, according to the American jibe, there are many less effective ways of increasing production.

In Defence of the National Health Services

There is no ambiguity in the statement concerning the position of the Minister and his staff. He is answerable to parliament but he and his staff "cannot and should not manage the Service themselves". The management is with the Regional Boards and the Management Committees. These bodies are not in charge as civil servants nor do their staffs rank as such. This scheme is run by a body of more than ten thousand voluntary unpaid workers, as well as thousands of people who, in some voluntary capacity, are rendering services to the patients. It may be added that out of the 364 members of the 14 regional boards, no less than 120 are doctors.

The memorandum suggests that there may be a change in the internal management of the hospitals which has not yet received general acceptance. It is proposed to abolish the medical superintendent, as he has been known in the past, although it is generally admitted that the best administered teaching hospital in London was under a medical superintendent and the Scottish hospitals are notable examples of the excellence of that form of administration. It seems to be the hospitals under local authorities which have created a prejudice against this form of internal government. The present proposal is that the hospital manager, whether layman or doctor, "will be a business manager". This is a matter of medical politics upon which it may be thought that it is not seemly for a layman to express an opinion but, from the point of view of the patient, it must be a medical man who has the administrative responsibility for the patient, involving on some occasions the necessity for giving treatment. Patients are not goods in a warehouse requiring merely a "business manager" for their adequate care.

Unfortunately, it has been necessary for the memorandum to give first place to hospital service, although it is recognized that "for nearly everybody the family doctor is the pivot of the whole scheme"; through him the patient should obtain access to the hospital and specialist services. Owing to a variety of causes, this provision is not operating adequately and until it does, the different branches of the service will not be placed in the relationship intended in the scheme.

Upon the conditions of employ-

(Concluded on page 98)

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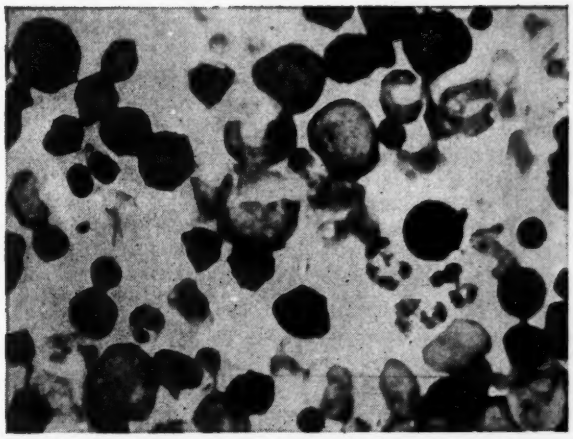
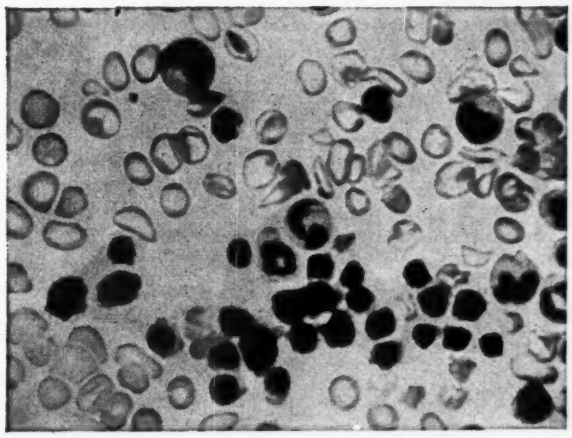


Smear showing megaloblastic bone marrow of patient with pernicious anemia before treatment with Cobione



Bone-marrow smear from same patient ninety hours after a single injection of 0.025 mg. of Cobione

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- **A pure, crystalline compound of extremely high potency.**
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- **Supplied in ampuls of 1 cc. of saline solution of Cobione, each cc. containing 15 micrograms of Crystalline Vitamin B_{12}.**

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The Uses and Value of Aureomycin

(Excerpts from an editorial in "Annals of Internal Medicine", published by the American College of Physicians, July, 1949.)

IF the new antibiotics isolated in the attempts to supplement the deficiencies of pencillin and streptomycin, aureomycin at present seems to be most promising. . . It is readily absorbed from the grastrointestinal tract, and effective concentrations in the blood are easily obtained after oral administration. It is excreted rapidly in the urine, maximally from the fourth to the eighth hour, in which it reaches high concentrations.

Aureomycin is relatively nontoxic. . . . Full therapeutic doses, administered orally, often cause some nausea and vomiting or mild diarrhoea. This is often relieved by aluminum hydroxide preparations, usually subsides after a few days and rarely necessitates interruption of treatment. If necessary supplementary parenteral injections of aureomycin in procaine solution may be given, although these are painful and may cause more or less troublesome local reactions. . .

Preliminary experiments with aureomycin in vitro indicated that it inhibits growth and in much higher concentrations is bactericidal for a large number of pathogenic microorganisms, including both Gram-positive and Gram-negative species. These included haemolytic streptococci, some strains of *Streptococcus faecalis* and other types of nonhaemolyzing streptococci, pneumococci, meningococci, gonococci, staphylococci, colon bacilli, typhoid bacilli and other Salmonella, Brucella, Klebsiella, and influenza bacilli. Proteus and *Pseudomonas aeruginosa,* however, were relatively resistant. Technical difficulties were encountered in these experiments as well as in titrations of aureomycin in the blood because the drug deteriorates very rapidly in dilute alkaline solutions. The presence of serum lessens its inhibitory action in vitro.

These results, in general, have been confirmed by animal experiments. . . .

In infections of the urinary tract favourable results were obtained in many cases, apparently quite equal to those of penicillin and streptomycin. These included cases of infection with colon bacilli as well as cocci, including strains of *Streptococcus faecalis* that were resistant to penicillin. Infections with Proteus and *Pseudomonas aeruginosa* appear usually to be resistant. . . .

Aureomycin was not effective in experimental infection with several unrelated viruses, including influenza B and one strain of poliomyelitis. . . .

Although the published evidence does not warrant a final conclusion as to the effectiveness of aureomycin. . ., it is obvious that the drug is of great practical value. Its activity extends over a far wider range of organisms than that of any antibiotic previously known. Its action on the rickettsaie and the psittacosis group of viruses is of great theoretical interest in that it is the first therapeutic agent which can penetrate the barrier of the cell membrane and effectively attack infectious agents which are ensconced within the tissue cells. Its apparent failure to affect other viruses may be disappointing but it is not surprising. The psittacosis viruses differ in many respects from the other viruses, and they seem in many ways more closely related to the rickettsiae and the "simpler" bacteria.

From the standpoint of administration, aureomycin offers many obvious advantages. It is highly effective when given orally. Thus far no serious toxic effects have been described, although gastrointestinal disturbances may be troublesome, especially if full doses (3 to 6 gm. per day) are required. Eventually evidences of toxic action and of sensitization may be anticipated, but it seems probable that these will be rare. Thus far there has been little if any tendency for susceptible organisms to become resistant. Experiments designed to accomplish this have resulted in only a relatively trivial increase in resistance as a rule, in sharp contrast to streptomycin. Until the present cost (at retail about four dollars a gram) is reduced, however, it is not likely to replace penicillin in the treatment of infections which are susceptible to the latter.

At present aureomycin is the treatment of choice if not the only effective measure in lymphogranuloma venereum, granuloma inguinale, in all rickettsial infections, in acute brucellosis, probably in primary atyptical penumonia and possibly in typhoid fever and other Salmonella infections, although the evidence of its effectiveness here is much less convincing. Aureomycin promises to be valuable as a substitute for streptomycin in infections with other Gram-negative bacilli, such as Klebsiella, Haemophilis and in tularemia, in which streptomycin-resistant strains have developed or in patients who show evidence of toxic injury from streptomycin.

The same is probably true of the usual coccal infections which are routinely treated with penicillin. Aureomycin has been used successfully, e.g., in certain cases of infection with penicillin-resistant strains of Staphylococcus, *Streptococcus faecalis* and *S. viridans* (in bacterial endocarditis). There is as yet no evidence that aureomycin would be superior to penicillin in most cases of such infections. Because of its wide range of activity, however, a strong tendency may be anticipated to administer aureomycin blindly to many patients with infections in which it is difficult or inconvenient to make a precise bacteriological diagnosis.

The relative value of chloromycetin and other new antibiotics can not be assessed at present. Chloromycetin is evidently more effective than aureomycin in typhoid fever. Undoubtedly the introduction of aureomycin marks an important advance in the treatment of infectious diseases.

The desire to take medicine is perhaps the greatest feature which distinguishes man from animals.

—*Sir William Osler.*

Provincial Notes

Nova Scotia

LIVERPOOL. The Queen's County General Hospital, capacity 39 beds, has been completed. The ground floor contains x-ray rooms, laboratories, E.E.N.T. department, and a fire-proof anaesthesia storage room, as well as kitchen, supply rooms, and tastefully furnished quarters for the staff. The main floor contains the administrative office, waiting rooms, operating and delivery suite and, in addition, accommodation for 24 patients. On the second floor are semi-private rooms and one general ward.

* * * *

NEW WATERFORD. Plans are under consideration for adding a new wing to the New Waterford General Hospital. It would provide over 100 beds, new surgical, medical and maternity sections, as well as x-ray and treatment rooms. The wing would contain a laundry, a kitchen, staff and help dining-rooms, and an out-patient clinic. The cost is estimated at $675,000.

* * * *

SYDNEY. Two hospital projects are under consideration in Sydney. St. Rita Hospital plans to build a new $1,500,000 hospital which will accommodate 150 patients. The City Council is also taking steps towards the construction of a large addition to Sydney City hospital. This increase in accommodation would relieve the acute shortage of hospital space which has existed for some time in the area.

New Brunswick

CHATHAM. Plans are under way for the construction of a new 75-bed wing for the Hotel Dieu Hospital. At present the hospital has a capacity of 65 beds but has been operating with over 82 patients daily. The hospital board hopes to commence building in the spring of 1950.

FREDERICTON. Dr. R. J. Dolan has been named director of hospital services and of the cancer diagnostic service of the New Brunswick Department of Health. After serving throughout the war, Dr. Dolan became superintendent of the Sussex Veterans' Hospital in 1946. His most recent work has been as district medical officer in Saint John for the D.V.A. In his new position he succeeds Dr. D. F. W. Porter.

* * * *

SAINT JOHN. Work on the million dollar construction program at Lancaster Hospital is progressing favourably. The foundation of the boiler plant has been completed and 75 per cent of the work on the foundation for the new three-storey wing has been done. This wing will contain new operating room services, a kitchen, dining-room, laboratories, storerooms and elevators.

* * * *

SAINT JOHN. Senior Major Nellie Bunnett has been appointed superintendent of the Evangeline Hospital. Major Bunnett spent 30 years in the Women's Social Service department of the Salvation Army. She served as superintendent of the Maywood Girls' Home, Vancouver, of the Bethany Hospital, Saskatoon, and, immediately prior to her appointment to Saint John, of the Vida Lodge for Girls in Toronto. Major Dorothy Wells, who is being transferred from the Catherine Booth Hospital in Montreal, will be Major Bunnett's assistant.

Quebec

MONTREAL. A committee under the chairmanship of Dr. F. Cyril James, with Dr. Basil C. MacLean as consultant, has submitted a report entitled, "An Interim Report on the Teaching Hospitals of McGill University". The report touches on the reconstruction of the Royal Victoria Hospital and on the enlargement of the Children's Memorial Hospital, and gives full details of the Montreal General Hospital project for the erection of a new $10,000,000 building. This new hospital would replace the central and western divisions of the Montreal General, would accommodate 500 patients (this number would be increased to 750 before the end of the project), and would supply rooms for 300 nurses. The object of this plan is to co-ordinate the teaching hospitals of McGill University into an impressive medical centre.

* * * *

MONTREAL. . Montreal is making plans to erect a new hospital to contain from 475 to 500 beds. It will be run by the Grey Nuns. The hospital, which is expected to cost $5,000,000, will accommodate approximately 300 adults and 175 children. Grants from the federal government will amount to $400,000 and, from the provincial government, to $1,600,000.

Ontario

FORT WILLIAM. Cool, colourful, and comfortably appointed is McKellar Hospital's latest addition, a quonset hut ward at the south-west side of the hospital. It was built and equipped at a cost of $60,000. The hut provides accommodation for 26 patients, and contains a nurses' station, a utility room, and a modern kitchenette.

* * * *

LEAMINGTON. Miss Mildred Maybee, formerly superintendent of nurses at the Metropolitan Hospital, Windsor, Ontario, has been appointed superintendent of the District Memorial Hospital at Leamington. The new 50-bed hospital which is now nearing completion will be ready to admit patients by the end of the year.

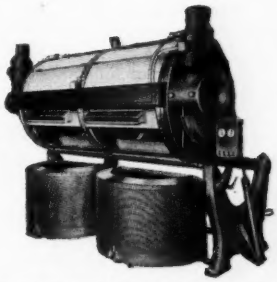
* * * *

HAMILTON. A two-storey brick building at the Hamilton General Hospital, known as Ward B, which was used as a ward for about 30

(Continued on page 72)

CHECK the SUBSTANTIAL SAVINGS Immediately Available with Modern HOFFMAN Laundry Equipment . . .

A fraction of a penny saved per pound of laundry can provide the dollars not now in your budget for critical needs. This fact is being demonstrated daily by the hospitals who have installed modern Hoffman laundry equipment. They cut their labor costs, their fuel and water costs, their floor space needs, and their expenses for soap and other supplies. The dollars and cents details for *your* operation are available with a Hoffman Laundry Engineering Survey. No obligation — write now.



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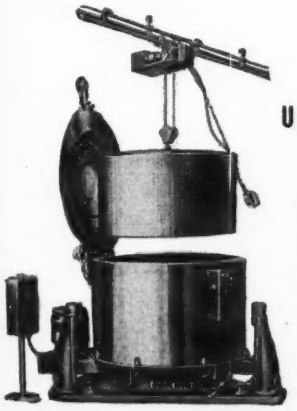
Cuts down pulling time and labor costs — cylinder raises hydraulically to deposit loads into extractor basket halves. Faster operation—more loads per day — saves floor space. 42-inch cylinder.



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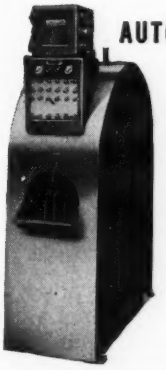
Reduces time and labor formerly needed for loading and pulling. Loaded basket halves carried by electric hoist (from washer) quickly lowered into this extractor, then raised for dump-out at finishing tables.



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Provincial Notes

(Continued from page 68)

incurable patients has been declared unsafe. The building was being remodelled for student nurses' classrooms when it was discovered that there was a six-inch outward bulge from the first storey to the eaves-trough. The building inspector recommended that the east wall be rebuilt and several other repairs be made.

* * * *

MOOSE FACTORY. The modern 120-bed hospital to serve the Indian population around James Bay will be completed by next spring. The new hospital is being built at Moose Factory at a cost of $1,500,000. Immunization, tuberculosis treatment, maternity cases, surgery and general hospital care will be handled at the new centre.

PETERBOROUGH. Work on the two hospital projects is progressing. It is expected that the new wing of the St. Joseph's Hospital will be completed by January. It will provide an additional 77 beds, as well as a new kitchen, which will cater to the entire hospital. Work on the east wing of the new 240-bed Civic Hospital has begun. This wing will provide 60 beds and 50 bassinets. The excavation for the nurses' home, which will be part of the hospital, has been completed.

* * * *

OTTAWA. The Queen Juliana Hospital Hut at Shirley Bay Boys Camp has been officially opened by Viscount Alexander. The hospital is named after the Queen of the Netherlands who lived in Ottawa from 1940 to 1945 and who contributed substantially to the construction of the hospital hut at the Y.M.C.A. camp.

* * * *

OTTAWA. The Royal Ottawa Sanatorium is building an addition which will contain 135 beds. The new wing will also contain an x-ray department, administrative offices, limited quarters for resident physicians, laboratories, and a dispensary.

* * * *

SUDBURY. A site has been selected on the shore of Lake Ramsay for the Sudbury and Algoma Sanatorium, the first tuberculosis institution of northeastern Ontario. The building will cost $1,500,000 and will contain 120 beds. It is expected that excavation will be completed this fall in order that construction may be carried on during the winter.

* * * *

TORONTO. The City Council has authorized use of Lambert Lodge, formerly Christie Street Hospital, as a home for the aged. A grant of 50 per cent of the maintenance costs will be received from the provincial government on condition that the city proceed immediately with the planning and construction of other adequate and proper accommodation for the aged. The Council recommended that the building be divided into three units —one for ambulatory cases, one for senile cases, and the third for those in bed. The building will house 300 aged persons.

* * * *

WOODSTOCK. Miss Helen Marsh, Reg.N., has been appointed superintendent of nurses at the Woodstock General Hospital. Since her graduation from the University of Western Ontario in 1948, Miss Marsh has served the hospital successively as science instructor and as assistant superintendent of nurses.

◄ 25 Years Ago ►

September, 1924

The new premises of the Notre Dame Hospital on Sherbrooke Street East, Montreal, opened on September 24th. Some 80 patients were admitted.

Dr. M. T. MacEachern, President of the American Hospital Association, told delegates that politics should be eliminated from hospital management. A hospital code of ethics was badly needed.

A declaration of war against the microscopic enemies of mankind and all the causes of disease was the keynote of the presidential address of Major-General Sir David Bruce at the opening of the British Association for the Advancement of Science. Sir David was head of the Lister Institute of Preventive Medicine in London, and stressed the adjective "preventive" in place of "curative" showing that medical science was assuming the offensive instead of awaiting attack.

Editorial comment was made regarding the radio installations in the new Hunts Point Hospital, a private hospital in the Bronx. Considerable technical difficulties were overcome in providing satisfactory reception through the headsets installed in each of the eighty rooms.

Vancouver General Hospital would benefit in about twenty years by a half-million dollars raised through contributions of life insurance policies payable to the hospital.

Miss Grace Fairley, superintendent of the Training School at the Hamilton General Hospital, was appointed *Lady Superintendent* of the Victoria Hospital, London, succeeding Miss Elizabeth Ross. Miss Edith Rayside of the Montreal General went to Hamilton.

A Toronto man was fined for securing hospital treatment for his wife as a poor patient while he was, at the time, well able to stand the expense.

The Toronto General Hospital bought one of the new "radio knives" for removing tumours.

Twenty-five patients from Christie Street Hospital went to the Red Cross Home for Invalid Soldiers at Hanlan's Point. The party remained three weeks, returning at the end of that time to leave room for another twenty-five. ●

Manitoba

BRANDON. Work is well advanced on construction of a new four-storey wing for the Brandon Men-

(Continued on page 108)


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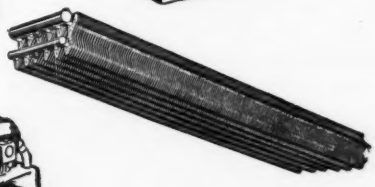

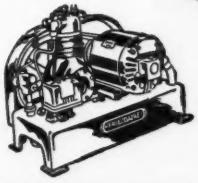

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Dietary Department

(Concluded from page 46)

on the floors assist in serving trays —as they should—for the feeding of the patient is just as much a function of the nurse as the administration of drugs or pills. In this case not so many aides are needed. Direct supervision of each tray is considered a part of every well organized indirect service for, as has been said before, modern hospitals using such a plan include in their staffs floor dietitians for the managing and supervising of the dietaries and trays of the individuals entrusted to their care. Indeed, there is much less likelihood of error, in special diets particularly, and if errors do creep in they are more easily corrected. Likewise, the person serving the tray is closer to and more directly interested in the patient's needs. Hence the service is more personalized. Individual desires can be considered and more easily satisfied. Between-meal nourishments and short orders at unusual times can be handled more readily. Distance from hot food supply, namely heated floor trolley, is shorter certainly than from central kitchen to these same patients. Therefore, under the decentralized system, there is more likelihood of keeping tray service where it belongs—in the realm of therapeutic treatment. After all, all treatment of the sick is individualized; feeding of the sick should not be reduced to a mass routine procedure.

In large hospitals, it seems desirable and reasonable to use the modern trayveyor system for large-scale feeding of patients. Efficient, time-saving, and labour-saving, these have much in their favour. Those who use them, however, have many points against them. The installation of the specialized equipment is very costly and its maintenance problematic. The concentration of all units into one area creates an overwhelming pressure of activity which is felt by all the workers. The mechanized action which demands great concentration and constant alertness proves nerve-racking after a short time. Individuals' choice of food, if allowed, complicates the serving and increases the nervous tension of those serving and checking. Errors are frequent. Because of the speed at which the tray must be set up, there is danger of a poor appearance. Special diets slow down the procedure very much and, even with the extra attention focused on them, the "hurry up" feeling may restrict a careful checking. There is danger that the patient in room 427 is not really a person to those serving her, but merely one of a number of unknowns.

When all is said and done, a large hospital will doubtless have to use such a system. It seems to most people concerned with the problem that this type of service is best used as *part* of the service, but that it must be supplemented always by some type of floor diet kitchen service available to the patient.

If *service to the patient* be our theme, the merits and demerits of each system must be measured by that standard.

Personnel Problems

Many of you are prone to shudder at the mention of this topic, I am sure. Heads of departments sometimes feel that their personnel problems are so complicated and complicating that they are beyond all solving. Perhaps one fundamental thought should be established: each person on the staff is a human individual with an individual character, personality, physical status, standard of living, and life problems. Working in the department is all a part of this.

Regardless of the type of worker he is, the employee must be trained in his specific task. First impressions are lasting. He should be shown the general over-all plan, his place in it, the importance of his work to the entire department, and then be taught how it is to be done. His wages and his hours must be comparable with those of others in the same field if he is to be content. Food service departments have a big problem with hours and arrangements of shifts to accommodate meal times. Straight hours are much more desirable than a broken shift, yet this is not always feasible.

The employee must be given safe and pleasant surroundings and working conditions, personal facilities, and good meals. He should feel that his job is important, that he has a chance for promotion, that he gets the same treatment and special considerations as others, and that the employment policies of the hospital are fair to all. He must know to whom he is responsible, that he is expected to measure up to what is demanded of him, and that if he has a complaint he can present it to the one in authority and receive just consideration. He plays an important role in the general welfare of the hospital and his worth must be realized and recognized by all concerned. Perhaps the simplest, shortest, most effective guiding principle would be: "Do unto others as you would wish done to you."

Role of Supervisor

The most ideal set-up, the most modern equipment, the best organized plan of service, the most desirable personnel do not guarantee an efficient department. True, these are the essentials for the greatest possibilities, but unless there is constant supervision on the part of the department head, backed by that of the administrator, the food service department will not measure up to the high standards which are set before it as its ideal. The dietitian is expected to organize, check, make necessary changes, adjust and adapt situations, integrate the various problems and solve all intricacies, make detailed inspections constantly, and sweetly but firmly demand the faithful observance of all regulations laid down for the efficient operation of her department. Human beings are human and carelessness slips into the best organizations. Unless the person in authority carries out her role as supervisor, failure will certainly harass the food service.

In many hospitals, non-sectarian as well as sectarian, the parable of the Good Samaritan is often depicted in art, prose, or poetry in some prominent place to indicate the policy on which the hospital endeavours to base its functioning. This is a good idea. If service to the patient be our ideal, the efforts to cope with the problems and vexations of the dietary department are challenges to our spirit of universal brotherhood.

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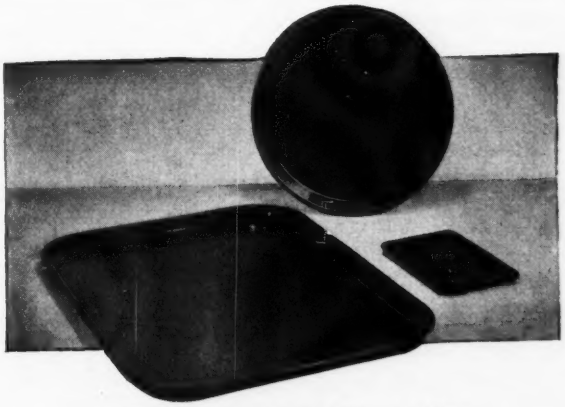


PLASTIC SERVING TRAYS—6 SIZES

Obstetrical Deaths

(Continued from page 40)

cases of haemorrage and shock, the two cases of toxaemia, the case of bowel obstruction, the death attributed to anaesthesia, and both cases of puerperal sepsis, (although one of those deaths attributed to sepsis also had a cardiac lesion).

In the *non-preventable* group were included all the cardiacs, the pulmonary embolus, the death from transfusion (though it should have been preventable in 1943), the case of bronchopneumonia and the death from necrosis of the liver. On this basis then, 8 were preventable and 7 non-preventable.

Haemorrhage and Shock

Two cases—both preventable. A review of these cases reveals the following pertinent contributing factors:

(a) manual dilatation of cervix
(b) failure to inspect the cervix following operative delivery
(c) version *and extraction* through partially dilated cervix for placenta praevia. Version alone might have been sufficient to control the bleeding and would have been much safer—the extraction is probably what tore the cervix and lower uterine segment. In such a case the baby is almost sure to be lost, but with caution the risk to the mother is greatly diminished.
(d) risk of post-partum haemorrhage after a precipitate delivery
(e) failure to closely watch the fundus after delivery
(f) failure to pack early
(g) failure to transfuse early
(h) uselessness of S & G to treat gross blood loss.

One case lived two hours, the other four hours—from this it is clear that we must act quickly to prevent these fatalities. We must not hope for spontaneous cessation of bleeding but we must inspect every case of bleeding to determine the site and cause of the haemorrhage. Above all, we must institute treatment before the patient's protective mechanism is exhausted.

Toxaemias

Two cases—both considered preventable. Both had cerebral haemorrhage after delivery. One 5½ hours later and one two days later.

The prevention of such fatalities depends of course on the co-operation of the patient in the ante-partum period, but we must recognize the risk associated with all types of toxaemia and hospitalize these patients early. Once in hospital we must watch them closely before *and after* delivery. In one of these cases (1939) the BP was not recorded before delivery (5½ hours after admission) and not for 5½ hours afterward and the patient died in another 5 hours time. Everyone who has ever cared for a severely toxic patient knows how trying they may be. But we must admit that in each case there is always at some stage an alternative termination that is less serious than the death of the mother.

Cardiacs

3 cases—commonest single cause. All classed as non-preventable. All had P.M. examination. All were primiparous and all young women, 20, 20, and 27. This supports the experience reported by some that this disease is much more serious in the younger age groups. Here we find the need to correlate our knowledge and if possible outline a better A.P. course and better method of termination of pregnancy. We must know how to arrive at a better assessment of these patients—possibly a routine chest x-ray would help and possibly we should avail ourselves of cardiac consultants earlier and more often than we do.

Puerperal Sepsis

2 cases—we must consider all cases of puperperal sepsis as preventable, for they, with rare exception, are clean before delivery. Both of our cases had retained placental tissue at autopsy. One died on the sixth post-partum day (very early) but this patient also had a cardiac lesion in the form of pericarditis. However, we have had no deaths since 1944 in spite of the fact that some patients must have had placental tissue retained—thanks to the newer and better antibiotics.

Miscellaneous Group

Two are considered to be preventable.

(1) Bowel obstruction — died in O.R. 42 hours after delivery.

(2) Anaesthesia—Patient had two anaesthetics in a few hours and at autopsy no other cause for death could be determined.

The others were:

Bronchopneumonia—1¾ hours in hospital after transfer from Beulah Home.

Pulmonary embolus—on the fifth post-partum day.

Necrosis of liver—following gastrectomy for massive gastro-intestinal haemorrhage.

Death following transfusion due to the incompatability of RH factors (1943).

Caesarian Section

Mention should be made of Caesarian Section for two reasons: first because 291 sections were performed during this time with no deaths (in fact the last fatality following section occurred in 1935); and secondly because the section rate has been increasing, reaching a new high of 2.26% in 1948. This rising rate, however, it is felt is not to be criticized as we have not had a death from haemorrhage and shock in the last 15,662 deliveries. In fact, one might speculate that had we done more sections we might have had fewer deaths.

Year	Sect.	% Rate	Death Rate	
1939	12	.84	.7	
1940	6	.43	2.84	
1941	22	1.54		1.08
1942	13	.85	.65	
1943	23	1.45	1.26	
1944	23	1.35	1.17	
1945	36	1.93	.53	0.63
1946	38	1.64	.43	
1947	60	2.25	.37	
1948	58	2.26	.77	
Total	291	1.57	.81	

Conclusions

(a) Excellent record considering our facilities.

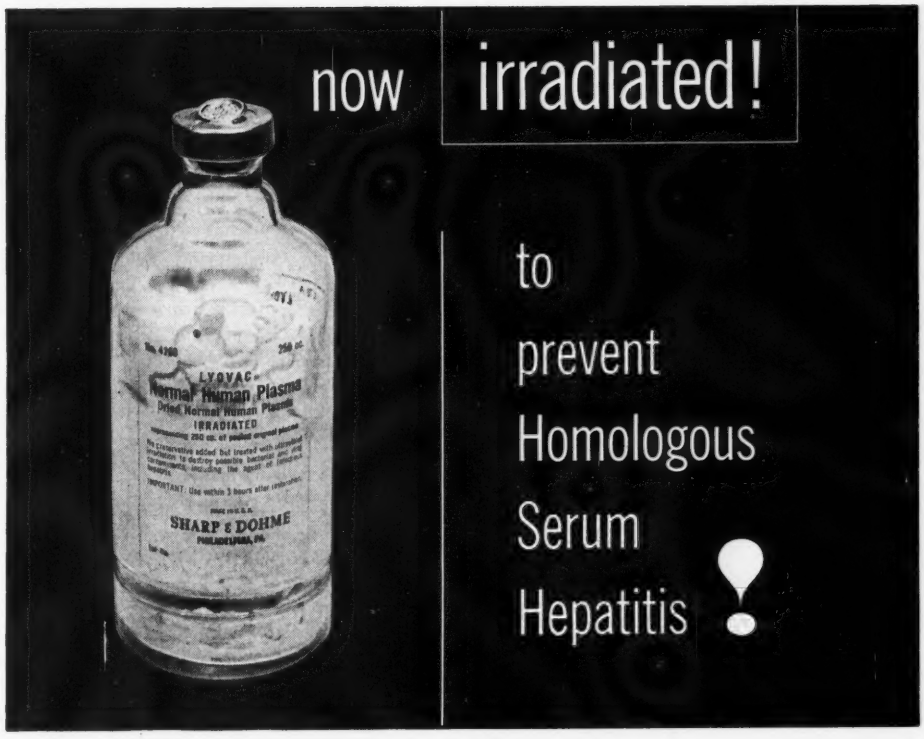
(b) No deaths from Caesarian Section since 1935.

(c) No deaths from H & S in the past 8 years and 15,662 deliveries.

(d) Cardiacs found to be commonest single cause of death during the last ten years while formerly toxaemias, haemorrhage and shock, and sepsis, were the leading causes of fatalities.

In spite of our reasonably good results, however, we can still further reduce our obstetrical mortality. Our "hind-sight" is always better, of course, than our "fore-sight" and we

(Concluded on page 104)



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Lyovac

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Normal Human Plasma IRRADIATED

Benefits to the Patient

(Concluded from page 31)

catheter must be properly placed and a six liter flow will deliver a high concentration of oxygen.

One point which is apt to be overlooked is *body temperature.* Some patients have hypothermia, others have hyperthermia. Hypothermia often occurs following avertin or pentothal anaesthesia, in which the respiration is depressed and the heat production is lowered. These patients vary in temperature according to their environment. Patients with hypothermia have a low blood pressure, slow pulse rate, and usually pale and cold skin. Lid and corneal reflexes are extremely sluggish and unconsciousness is prolonged. A rectal thermometer usually tells the story. Often in these cases a baker or heater is used, but they afford an extremely slow method of raising the temperature of the entire body. Perhaps the most efficient manner of raising body temperature is by the intravenous injection of small amounts of coramine, or some other analeptic. Coramine is safer to give intravenously and will raise the body temperature two or three degrees in a short time. Many have survived very low temperatures. In one instance a temperature of 75 degrees Fahrenheit was reported with subsequent recovery.

On the other hand, hyperthermias may develop on the operating room table. They are probably due to several factors — excessive bundling of patients, scopolamine in premedication, absorption technic of anaesthesia, or some interference with the central heat regulating mechanism. The temperature must be reduced by the removal of clothing or by the flow of cool air over the patient's body. In extreme cases it is necessary to cover the body with a towel soaked in cold water, though such drastic methods seldom are required. Generally an oxygen tent used as an air conditioner will be sufficient, or even an air conditioned room, if such is available, will lower the body temperature, quiet the breathing, and reduce oxygen requirement.

If *pain relief* is required, small intravenous or subcutaneous injections of morphine or demerol are useful.

The Nurse

The recovery room *nurse* carries out several functions:

(a) Protects the befuddled patient from injuring himself;
(b) Maintains a good airway and therefore helps avoid anoxia in the unconscious patient;
(c) Supplies oxygen therapy if requested by the physician;
(d) Records the blood pressure and pulse rate to detect changes in circulation;
(e) Cares for the transfusions or infusions which may have been commenced in the operating room;
(f) Reports if patients are in pain to the physician who may order the administration of a sedative;
(g) Takes the rectal temperature and reports unusually high or low readings;
(h) Administers antibiotics ordered by the surgeon.

In most hospitals the recovery room is a hive of industry very much like the operating room. It has concentrated most of the acute treatment in a thoroughly equipped room. It has made obsolete the scattered inefficiency and turmoil which prevailed in the many parts of the hospital attempting to care for the recovering patient.

Conclusion

There is no doubt that post-anaesthetic observation rooms are here to stay. Their worth to the patient, surgeon, anaesthesiologist, and nursing staff cannot be over-emphasized. Because of them many a brilliant and satisfactory surgical procedure which might have resulted in a post-operative fatality has been rewarded with success by the survival of the patient.

Organization and Equipment

(Continued from page 32)

and from the operating room in his bed as this obviates unnecessary handling.

(If you intend to treat short stay cases in your P.A.R., it will be necessary to set up two or three beds for such patients.)

Bed Sides: A sufficient number of suitable crib sides or side boards should be available for all the beds that may be in the P.A.R. at any one time. Some patients will be returned to the floor with the crib sides still attached, but in other cases these will be removed or not used, so that one set for each bed in the department should be sufficient.

I.V. Stands: Intravenous therapy frequently is continued following operation and there should be at least one intravenous stand for every two beds and at least twice as many sterile sets each day as there are stands.

Solutions: A stock of saline and glucose solutions should be maintained in the P.A.R. as well as plasma (which might also be required for emergencies). If whole blood is indicated and ordered preoperatively by the doctor, any such remaining blood should be returned with the patient from the operating room.

Suction: It is essential to have good suction readily available for any patient. It is ideal to have the suction piped to each bedside from a central pump, but, if this is not feasible, the portable suction apparatus is satisfactory. Water suction has a good vacuum but sometimes does not provide sufficient volume to be very effective in dealing with a large quantity of heavy mucus. On the other hand, water suction may be needed in some hospitals as a standby in case of power failures.

Oxygen: The best arrangement is to have oxygen piped to each bedside from a central manifold, as this avoids the necessity of handling heavy equipment in the P.A.R However, it is not essential to bring on the oxygen through a manifold and we have found it satisfactory to supply the P.A.R. with a few oxygen tanks and sufficient masks and catheters for every two beds.

Resuscitation: Once in a while a real emergency will occur in the P.A.R. and it is advocated that an inexpensive bellows type resuscitator be available for immediate use.

(Concluded on page 88)

Organization and Equipment

(Concluded from page 84)

Instruments: The list of instruments for the P.A.R. inventory should include a stethescope, a blood pressure set, a cut down set, a few sterile sets for the administration of sedatives, analeptics and antibiotics, dressing forceps, thermometers, tongue depressors, swabs, and the usual items found on a ward dressing carriage.

Utensils: Kidney basins, bed pans, urinals, and the usual items supplied to a ward service room.

Furniture: There should be a good scrub sink for the cleaning of instruments and utensils and for a water supply. The nurse's desk should have a chart rack as the patients' charts are taken to the P.A.R. and entered before the patient leaves. A wheel chair is necessary for the discharged short stay cases, and a small linen cupboard is required for the storage of linen and rubber goods.

Some hospitals have combined their emergency department with the post-anaesthetic recovery room. This is not a bad idea if you have sufficient room for such a project in your operating room area or adjacent to it. Such a system provides a twenty-four hour coverage and much the same equipment is required for both activities. No matter how humble your post-anaesthetic recovery room may be, you will receive everyone's blessing for establishing such a service.

Definition of Prescription

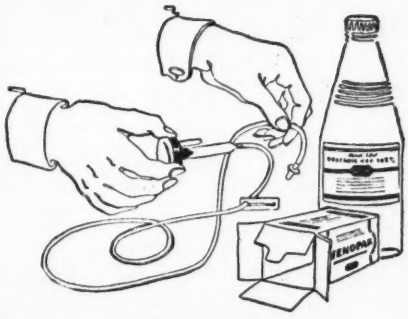
The recent revision of the food and drug regulations (P. C. 1536, 5th April, 1949) has effected a clarification of the so-called prescription drug order which limits the sale of certain drugs to prescription only.

1. One obscurity has been removed by the definition of the word prescription. A telephoned order does not constitute a prescription, but a pharmacist may execute an order over the telephone in an emergency for any of the drugs in question provided he be supplied with a written prescription covering them within 24 hours.

2. The definition of prescription does not mention refills, but the prescriber is free to specify in writing how many times it may be repeated, and the pharmacist is entitled to honour such directions. The actual number of refillings must be specified on the original prescription.

3. A pharmacist is within his rights to decline to fill a prescription if he has reason to believe it has not been presented in good faith, that it is an attempt to circumvent the law, or that it has been tampered with.

4. Since the pharmacist is responsible for having in his possession properly authorized prescriptions for drugs on the list which he has sold, it is the duty of prescribers to supply such prescriptions immediately. A pharmacist, accepting a telephone order for these drugs in an emergency, relies on the good faith of the prescriber to cover the prescription within 24 hours after giving the order for them. Prescribers, therefore, are urgently requested to cooperate with pharmacists in this important detail.



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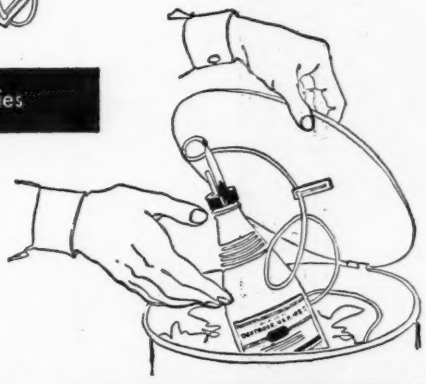

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Survey of Courtesy Discounts

A survey has been made by the Saskatoon City Hospital, Saskatoon, Sask., requesting information on the vexatious problem of dealing with courtesy discounts. Forms were sent out to 14 large hospitals between Calgary and Ottawa and the data supplied in the replies with respect to a variety of discounts may be summarized as follows:

Discounts to	Full	Partial	None
Board Members	21% (of hospitals replying)	14% (of hospitals replying)	65% (of hospitals replying
Medical Staff	50%	36%	14%
Clergymen	—	36%	64%
Medical Staff Families	7%	64%	29%
Own Graduate Nurses	36%	57%	7%
Other Graduate Nurses	14%	36%	50%
Hospital Staff	36%	22%	21%

(It was reported that 21% of hospital staff were covered by Blue Cross or Saskatchewan Hospital Services Plan.)

Canadian Arthritis Society Announces Details of Fellowship Program

The Canadian Arthritis and Rheumatism Society has adopted a program of fellowships for the post-graduate study of rheumatic diseases at university centres in Great Britain, the United States, and Canada. These fellowships are particularly designed for those desiring further training in internal medicine.

Thus far training opportunities have been arranged in Massachusetts General Hospital, Harvard, Hospital of University of Pennsylvania, Philadelphia, and Michael Reese Hospital, Chicago, all tenable October 1st, 1949; and in West London Hospital, London, and Royal Infirmary Hospital, Manchester, England, tenable January 1st, 1950.

The West London Hospital, London, will accept two fellows, the others one each. Each of these hospitals has a rheumatism department and extensive diagnostic and therapeutic resources. Those supervising the training are well known internists who have been giving leadership in the study of rheumatic diseases.

The fellowships will vary in amount from $2,000 to $4,000 per annum, for one period of twelve months, and the Society will pay the fellows' travelling expenses from their place of residence in Canada to the place of training and return. Fellows will not be required to give any particular undertaking other than that they ultimately intend to return to practise in Canada.

In general the Society would wish to award fellowships to physicians who, on the completion of their post-graduate training, are likely to receive teaching appointments. In consequence, recommendations from Deans of Medicine, together with an outline of the total post-graduate training which the candidate hopes to undergo and his prospects for ultimately receiving a teaching appointment, will be factors in determining awards.

It is anticipated that candidates for these fellowships will be seeking certification or fellowship in the Royal College of Physicians (Canada), if not already so qualified. Accordingly, individual clearance with the Royal College will be desirable.

Additional information will be gladly supplied to universities or to candidates by Edward Dunlop, Executive Director, Canadian Arthritis and Rheumatism Society, 74 Sparks Street, Ottawa, Ont.

Auxiliary Nursing Service

(Concluded from page 42)

the empty bed while she is doing the treatment. We have found this team work on an active ward very satisfactory.

When the nurses' aides have had some experience, they each take their turn working on the 2.30 p.m. to 10.30 p.m. shift. They give the nurse valuable assistance with the afternoon and evening work. The nurses' aide is paid $50 per month, with meals during her course, and at the completion $70 per month with a $5 increase every six months until a maximum of $90 a month is reached. Each member of this group is told about the nine months' course for certified nurse assistants which is given through the Ontario Department of Health and is encouraged to take this training. It gives her increased nursing knowledge and a status in the nursing field. We have one nurse assistant in our hospital.

It is desirable to have one person definitely in charge of the auxiliary nursing services, preferably a nursing art instructress, one who is fond of working with individuals, one who is willing to listen to the individual's problems. There is a great deal of counselling to be done with this group. A little sympathy and understanding of their viewpoint and a little kindly guidance usually makes for a happier relationship between individuals and between groups, and consequently better work.

To maintain the interest and to further the education of the entire auxiliary group, meetings are held, problems discussed, educational talks given, and films shown. Many of the auxiliary workers, as they have proved their worth, have been promoted to more responsible posts. Some have completed the necessary educational requirements and entered the training school for nurses.

Conclusion

There may be some disadvantages in the use of auxiliary nursing service in the hospital. The personnel is less stable, the wastage is greater than with a more professional group and at times seems very great.

On the other hand, there are many advantages. The ward aide performs many non-nursing duties previously carried out by the nurse. The nurses' aide and nurse assistant spend hours giving necessary routine nursing care, leaving the nurse time for the treatments and more technical procedures for which there is an increasing demand as medical science advances. As for personnel wastage, is not the hospital the core of health teaching in the community? Will not these people who leave our ranks be of more value to the community because of the training which they have had? They all came to the hospital because they had a desire to nurse. Even in their homes, then, they will make a better job of caring for the sick.

The treatment of high blood pressure is a regimen, not a drug.—*Huchard.*

Hospital Administration

(Concluded from page 39)

pressed as to how best to meet these demands. Certainly new construction is needed in many areas but no building should be begun until a thorough study has been made by those competent to judge. Among the latter should be included responsible lay members of the community as well as the architect and hospital consultant. In larger areas there should be an over-all planning committee to ensure an equitable distribution of hospital accommodation. In this regard, we would be well advised to take a page from the experience of two large cities, New York and Philadelphia. New construction must be based on the proportionate need for single and multiple occupancy rooms. Consideration must be given to the provision of facilities for the chronically ill and the convalescent.

The advisability of establishing a diagnostic clinic for ambulatory patients of the middle income group should be considered as a means of lessening the load on in-patient care.

The principle of maintaining full time members on the attending staff, especially heads of departments, is being gradually and more widely accepted in the teaching hospitals. This would seem to be a desirable trend in view of the considerable increase in both administrative and teaching responsibilities over those of a generation ago.

The trend toward uniform accounting needs no further comment except to extend grateful thanks to those who have made it possible.

It is of interest to note that across the border, at least, the all-inclusive rate is being replaced by the former system of separate charges.

We of the voluntary hospitals are most concerned, to put it mildly, about our financial position. We see expenditures still outpacing increased income. We see a sympathetic public doing its share in helping to meet our deficits. We fail to see, however, governments pay per diem costs of the indigent which we submit they should pay upon a negotiated basis and without interference with the autonomy of the hospital. As I see it this is the one most important problem of the day—to convince governments of the responsibility they must assume if the doors of voluntary hospitals are to be kept open.

A.C.H.A. to Hold Convention and Convocation in Cleveland

The 15th annual convention and convocation of the American College of Hospital Administrators will be held in the Hotel Statler in Cleveland on September 24 to 26. This meeting will immediately precede the convention of the American Hospital Association.

Convocation will take place on the afternoon of Sunday, September 25th, followed by the President's reception and the annual banquet in the evening. The general educational session will be held on Monday, September 26th, with the President, Miss Jessie Turnbull, presiding.

400 Women Expected at Second A.H.A. Hospital Auxiliary Conference

Mrs. Corena McCallum

Some 400 delegates from hospital auxiliary units in the United States and Canada will get together in Cleveland from September 26 to 29 to attend the second conference of Women's Hospital Auxiliaries to be held in conjunction with the annual American Hospital Association convention.

The conference program, mapped out by the Association's Committee on Women's Hospital Auxiliaries, will include informative sessions on auxiliary projects, hints on operating the service units, and general background of hospital service work. The newly-formed Committee on Women's Auxiliaries, of which Mrs. Corena McCallum is secretary, has been working on plans for the setting up of a program for women's hospital service groups on a national level and promoting statewide organizations. Plans for these projects will be under discussion at the conference.

* * * *

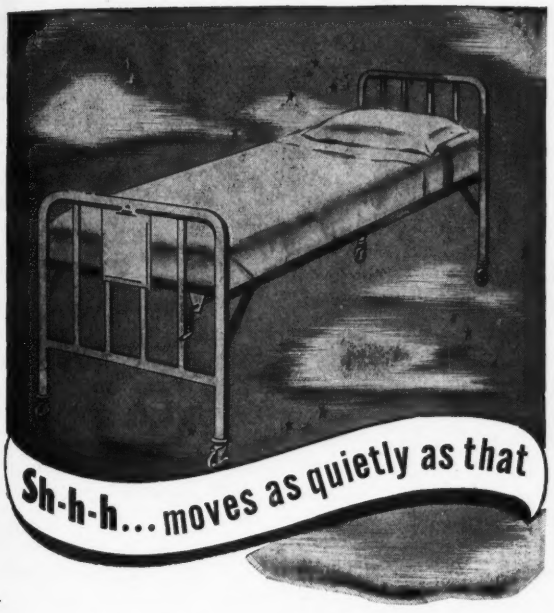
Wadena Aids Have New Project

The Women's Auxiliary of the Wadena Union hospital in Saskatchewan have undertaken a new project. They are going to raise money to install an inter-communication system in the hospital. The auxiliaries are also trying to determine what articles they should buy to furnish a sitting-room for members of the domestic staff. The ladies are planning to hold a bazaar in the fall to raise money to carry out their projects.

* * * *

Windsor Aids Busy With Country Fair

The members of the Metropolitan General Hospital Women's Aid are holding their annual Country Fair on September 16. Among the special features this year will be draws for a television set, a petit point bag, and a plane ride. There will be various booths, an apron booth, the treasure booth, the handicraft booth, and the merchants' booth. Pony rides, balloons, a fishpond, and a popcorn wagon will be specialties for the small fry. Tea will be served in the afternoon, and, to add to the fun, a fortune teller will be present. Tickets for the dinner, which is one of the highlights of the fair, are now on sale.



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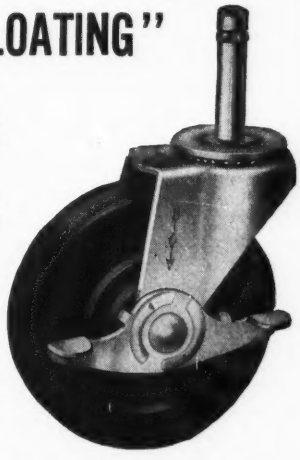

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American Hospital Association Plans Attractive Meeting

An excellent program has been arranged for the Cleveland meeting of the American Hospital Association, September 26 to 29. President Joseph Norby, Secretary George Bugbee, and their committee have selected a number of very vital topics for discussion and the speakers assigned to them should attract a large attendance.

Among the topics being considered are: "How can Voluntary Enterprise and Government Work Together?"; "What Organized Labour Desires" by Walter Reuther, the C.I.O. leader; a panel on the technical departments; government health plans in Canada and Great Britain; construction trends; Blue Cross and hospitals; isolation technique in children's wards; the function and work of hospital consultants; purchasing agents' problems; state surveys and co-ordinated planning; "Women's Auxiliaries in Action"; a symposium on "Quality of Hospital Care and Organization for it"; internal organization and supervision. There will be a "Get-Together Night" for an informal reception and supper on the 26th and the annual banquet will be on the Thursday night.

Dr. Fred D. Mott, chairman of the Health Services Planning Commission of Saskatchewan and Dr. J. M. Hershey, Hospital Insurance Commission for British Columbia, will present Canada's governmental hospital insurance plans. Dr. A. Leslie Banks, principal medical officer, Ministry of Health, London, will discuss "The Government Health Program in Great Britain". Judge J. Milton George of Morden, Manitoba, will participate in a panel on the application of Canadian and British experience to the American scene.

Other Canadian participants will be Dr. J. E. deBelle of Montreal, chairman of the A.H.A. committee on children's hospitals, and Dr. Harvey Agnew. A number of expatriates, include Dr. M. T. MacEachern, Dr. Alan Craig, and Dr. Basil MacLean.

Hospital tours are being arranged and the Cleveland Indians and Detroit Tigers will be playing on the 24th and 25th.

Provincial representations of the House of Delegates are reminded of the sessions at 9.30 a.m., Sunday, September 25, and on the evening of Wednesday, the 28th.

Hotel reservations should be attended to as soon as possible.

Ethical Infants

We have grasped the mystery of the atom and rejected the Sermon on the Mount. Man is stumbling blindly through a spiritual darkness while toying with the precarious secrets of life and death.

This world has achieved brilliance without wisdom, power without conscience. Ours is a world of nuclear giants and ethical infants . . . *General Omar N. Bradley*

◀ Blue Cross ▶

Ontario Blue Cross Provides Employee Suggestion Boxes

As a project for furthering employee interest in their work with the Blue Cross and to provide them with a proper channel through which they may express their ideas, suggestion boxes were recently placed in strategic positions throughout the Plan Offices and a committee was appointed to study any suggestions received. The executive felt that an interested employee, being intimately in touch with the particular task he or she is performing, is often in a position to think of a better way of doing it.

* * * *

New Blue Cross Division Established

The Blue Cross Commission of the American Hospital Association has announced the establishment of a *hospital relations division* to deal with the problems of mutual interest to the Blue Cross and the hospitals. The new division will be headed by James R. Gersonde, former administrative assistant to Dr. Malcolm T. MacEachern, Director of Northwestern University School of Hospital Administration. The division will maintain close liaison with the American Hospital Association's headquarters staff and the A.H.A. Council on Prepayment Plans and Hospital Reimbursement.

* * * *

Blue Cross Awards

Winner of this year's prize for the best over-all Blue Cross public relations program was Massachusetts Hospital Service. Other awards were given for outstanding specific public relations projects. Winner of Class 1 (plans with more than 500,000 members) was Connecticut Hospital Service. Class 11 (200,000 to 500,000) was won by the Central Hospital Service of Columbus, Ohio. Class III (100,000 to 200,000) was won by Hospital Plan Inc., Utica, N.Y., and Class IV (less than 100,000) by Northwest Hospital Service which covers the state of Oregon. Among the plans which were awarded certificates of Honourable Mention was the Blue Cross Plan for Hospital Care, Province of Ontario.

Federal Grants

(Concluded from page 54)

value of foods when eaten alone or in combination with other foods.

Tuberculosis

A grant of $4,300 has been allotted in New Brunswick to enable three sanatoria, St. Joseph's, the Jordan Memorial, and the Moncton Hospital to extend their present rehabilitation programs. Funds have also been set aside to buy additional orthopaedic equipment for the Moncton Tuberculosis Hospital and x-ray equipment for the Saint John Tuberculosis Clinic.

A tuberculosis control grant of $63,000 has been made to finance a hospital admission chest x-ray program in smaller hospitals throughout Ontario. A total of $8,000 has been earmarked to provide free pneumothorax refills for ex-sanatorium patients. A sum of $10,000 has been allocated for the purchase of special treatment equipment and $10,000 for the maintenance of patients at the Ongwanada Sanatorium, Kingston. Funds have been set aside to buy two sets of lung immobilizers, used in the treatment of far advanced cases of tuberculosis. This equipment can be moved from sanatorium to sanatorium as needed.

Funds have been allowed for the salary of an additional medical officer for the provincial tuberculosis dispensary in Newfoundland. The dispensary acts as the provincial centre for tuberculosis control.

Hospitals in Britain

(Concluded from page 60)

ment of medical men, it is made clear that they are entirely under the control of professional bodies known as Executive Councils. It is not an "employer-employee" relationship in the ordinary sense.

My aim in this letter has been to establish some perspective in the consideration of the whole subject. To add a personal note, in this as in previous letters, the point of view which I have adopted is one shared with one of the most eminent leaders of the medical profession, a man who has taken a leading part in all negotiations with the Minister. Men of goodwill are anxious to make the whole scheme work well for the sake of the people of this country.

Hospital Laundry Operation Manual

A new manual compiled by the American Hospital Association's Committee on Laundry Management sets up a yardstick for the efficient operation of hospital laundries. The publication, entitled "Manual on Hospital Laundry Operation", is scheduled for distribution to Association institutional members as a membership service.

Of interest not only to the laundry manager, but also to the administrator and other staff members, the manual gives a clear presentation of laundry needs, procedures, and the effect of efficient laundry operation on total patient care. The book will be invaluable to hospitals with laundry plants and to administrators interested in installing laundries.

Insurance Protection of Hospitals

In a survey just completed by the American Hospital Association, it was revealed that an average of only 12.8 per cent of the total insurance premiums paid by hospitals for fire, public liability, and malpractice insurance was returned in paid claims. Of the total of $11,-264,240 paid by the hospitals for these three types of insurance protection, insurance companies paid back $1,430,930 in settlement of claims.

Ritz E. Heerman, who served as chairman of the insurance committee, stated that from these figures he felt insurance rates for hospitals were not entirely equitable. He mentioned a few factors which had influenced the situation. With reference to fire insurance, hospitals are classified with other public buildings, although these latter do not usually have the safeguards, from the point of construction and preventive measures, in organization that are found in hospitals. In public liability insurance, hospitals have been rated on an area basis the same as other buildings. This is an injustice due to the fact that hospitals, as a general rule, carry malpractice insurance which protects the patients. Therefore, public liability insurance in hospitals seems to apply to visitors only, while in all other public buildings the public liability must cover not only the occupants of the building but also visitors. Hospital malpractice insurance has never been considered by rating bureaus in a separate classification from hospital public liability insurance and, in fact, most rating bureaus do not attempt to set up standard rates or tabulate experience. The few companies that now write malpractice insurance write it only in the areas where they have good experience.

The Association's Insurance Committee plans to work with the insurance companies towards achieving the following objectives:

1. to secure their interest in setting up a rating bureau for malpractice and public liability insurance in hospitals;

2. to suggest standard rates for these types of insurance;

3. to secure their co-operation with the Association in compiling experiences and to develop a safety program that will ensure the interest of all hospital administrators in carrying out standardization of procedure and regulations;

4. to develop with the insurance companies improved uniform standards of inspection and reports.

Pharmacists Salary in a 200-bed Hospital

It is admitted by both hospital administration and the pharmacy profession as a whole that salaries of hospital pharmacists are low, much lower than in retail. This is explained by hospitals by the fact that there has been compensation in shorter hours, no night work, free medical services, and one or more free meals. They also contend that these attractions, at lower salaries, more than offset the higher wages paid elsewhere or the hospital pharmacist would leave his position for a more remunerative occupation. The profession of pharmacy, outside of hospital pharmacy, has nothing to say because it knows

very little about hospital pharmacy and is concerned with merchandising problems and securing sufficient help for its own needs.

At a meeting last year, a secret survey of salaries was made among nine hospital pharmacists in the group. The lowest salary was $1,600 and the highest $3,600 per year. Recently a questionnaire was submitted to the graduating class at the O.C.P. Only seven (6 women and 1 man) expressed a wish to enter hospital pharmacy on graduation. The main reason given by the others for not seeking hospital pharmacy careers was the low salaries offered.

We believe the situation is improving. Colleges are awakening to the importance of teaching the subjects pertaining to hospital pharmacy and hospitals are realizing the advantages of appointing qualified pharmacists to supervise pharmaceutical activities.

The most recent appointment coming to our notice was in a one-pharmacist institution at a salary of $3,000 per annum. — *The Hospital Pharmacist, May-June, 1949.*

Ontario Transfers Hospital Heads

A rearrangement of six posts in Ontario hospitals has been announced by the Minister of Health, R. T. Kelley. Dr. Stanley R. Montgomery takes over as superintendent of the Ontario Hospital School at Orillia, succeeding the late Dr. S. J. W. Horne.

Dr. Charles A. Cleland has been appointed superintendent of the Ontario Hospital at Toronto and assumed his new duties on September 1st. Dr. John R. Howitt is the new superintendent of the Ontario Hospital at Fort William, succeeding Dr. Cleland to this position.

Dr. C. Foster Hamilton has been appointed head of the Ontario Hospital at Cobourg, while Dr. H. R. Brillinger will assume the post of assistant superintendent of the Ontario School at Orillia. Dr. J. D. Grieve has been appointed director of the Mental Health Clinic at Hamilton, succeeding Dr. Brillinger.

The rates of *pay* are not too high, but the rates of *production* are too low.—*John Flood, Saint John.*

Hospital Standardization Conference To be Held in October

The twenty-eighth annual Hospital Standardization Conference will be held at the Stevens Hotel in Chicago, October 17 to 21, as part of the Clinical Congress of the American College of Surgeons.

Eminent leaders in their respective fields will lecture and conduct panel discussions on subjects including trends in legislation affecting hospitals; standards of service rendered by the radiologist, pathologist, anaesthesiologist, and physiotherapist; standards for the institutional care of psychiatric patients in mental and general hospitals and of tuberculous patients in sanatoria and general hospitals; co-operation from the standpoint of the doctor, the trustee, and the administrator; and hospital costs and the maintenance of standards.

The first Hospital Standardization Conference was held in Chicago 32 years ago when delegates from the American Hospital Association, the American Medical Association, the Catholic and Protestant hospital associations, and other medical and hospital organizations approved the proposed plan of the American College of Surgeons to conduct a survey and approval program.

Ultraviolet Radiation

The use of ultraviolet radiation for the sterilization of the air in the operating room should be limited to those few surgeons who are cognizant of the biophysics involved and who understand its limitations and its hazards. Ultraviolet sterilization of the air is an unjustifiable luxury in any hosital unless all other equipment essential for the safety of the patient has been provided and unless an ideal aseptic technique is wholeheartedly enforced, because more organisms are introduced on fingers, instruments, and dressings than ever fall into the wound from the air.

Ultraviolet radiation can be used most advantageously to control the spread of respiratory infections. To be successful, however, an adequate installation is essential. Makeshift installations may be dangerous and ineffectual. Radiation of only upper air is useless. Curtains or barriers of ultraviolet of adequate intensity to effect practically 100 per cent killing must be used. Safeguards against excessive exposure of the occupants of the room must be provided.—*"The Aseptic Treatment of Wounds" by Carl W. Walter, A.B., M.D.*

Exodus of Doctors and Nurses to U.S.A. Causing Concern

Health authorities have expressed some concern because the annual emigration of nurses and doctors to the United States is close to 1,000, while members of these professional groups are so badly needed to help build up the Dominion's health services. Figures released by the Department of Labour indicated that last year 933 crossed the border, compared with 635 in 1947 and 350 in 1946, a jump of 300 per cent in the three-year period. Officials explained that the initial urge among both doctors and nurses who go to the U.S.A. is to secure post-graduate training but they admitted that only a fraction of them returned.

Unesco to Stimulate Exchange of Literature

Unesco proposes to publish later in the year a *Manual on the International Exchange of Publications.*

It is intended to publish as an appendix to this manual a classified list of institutions, including libraries, universities, scientific institutions, and learned societies, et cetera, throughout the world, which are willing to exchange either their own publications or other publications which they have regularly at their disposal. All institutions which have not so far sent to Unesco details of their exchange material in one form or another are therefore urged to communicate the following information to the Unesco Clearing House for Publications, 19 Avenue Kléber, Paris, 16:

(a) Name and full address of the institution.

(b) Exact titles of publications offered. (In case of duplicates offered for exchange purposes actual lists of duplicates are not required, but only a statement that lists of duplicates are available.)

(c) Institutions, which wish to exchange their publications only under certain conditions, are asked to state what these conditions are.

Only information which reaches Unesco before October 1st, 1949, can be used in the Manual.

Caven Memorial for Medical Research

A new medical research institute, to be known as the W. P. Caven Memorial Research Foundation, has been made possible by the bequest of $100,000 for medical research by the late Dr. W. P. Caven, and other donations. Completely independent of the University of Toronto, the Foundation has been given the widest scope under the terms of incorporation, being permitted to carry out medical and surgical research in Ontario or elsewhere. Dr. Herbert A. Bruce, surgeon, Dr. Robert J. MacMillan, physician, and Hugh Johnston McLaughlin, solicitor, will serve as directors of the Foundation and the research work will be under the guidance of Dr. D. W. Gordon Murray. The home of the new Institute, a large brick house purchased for $17,000, is located near the Toronto General Hospital, Wellesley Division.

Chief of Medicine Appointed at Toronto Western Hospital

Dr. W. Hurst Brown has been appointed to head the department of medicine at Toronto Western Hospital. A Rhodes scholar, Dr. Brown is the only Canadian ever to be awarded a Radcliffe Travelling Fellowship from University College, Oxford. He spent seven years in research work at the University of London. On the staff of Toronto Western Hospital since 1936, he was on leave of absence during the war when he organized a department of medical research in the Canadian Army Medical Corps.

In his new position, Dr. Brown will also hold the rank of associate professor of medicine at the University of Toronto.

Ottawa Civic Cleared

(Concluded from page 36)

newspaper and it published serious charges, and that it should produce evidence to substantiate them. It did not do so in some cases. No other witnesses were forthcoming, and I can only conclude that there is no available evidence to substantiate them."

Mr. C. J. Woodsworth, editor-in-chief of the Ottawa *Citizen* came in for some awkward questioning. Accepting responsibility for the editorials, he admitted that he had not taken these criticisms up with the trustees first, nor had he made any attempt through any channels other than publicity to have the institution improved. Although the witness objected to doing so, the Commission required him to explain what he had meant by "services far below the minimum standards called for". He admitted he did not know of any such accepted standard. Repeatedly the Judge stated: "If there is no evidence supporting their contentions, I must find them baseless."

Obstetrical Deaths

(Concluded from page 80)

can look back and know what might have been done. We must now use this knowledge to help us prevent similar tragedies in the future. We must therefore not forget the following:

1. The unpredictable nature of any toxaemia.

2. The common hazards of labour and delivery, and the greatly increased dangers of operative obstretrics. We must examine all patients after operative delivery or unusual manipulations to look for evidences of trauma. We must know where the bleeding is coming from. The treatment of all complications must be prompt and decisive.

3. We must attempt to assess more accurately our cardiac cases.

4. We must always remember the hazards of anaesthesia when the patient is so often ill-prepared and when facilities are not the best.

5. Finally, I feel that a great deal of credit for our good results must be given to the nursing staff who, in my experience, have been most diligent in the care of sick patients.

Let us treat the men and women well: treat them as if they were real; perhaps they are. —*Emerson.*

Coming Conventions

Sept. 24-25—American College of Hospital Administrators, Cleveland.
Sept. 26-29—American Hospital Association, Cleveland.
Oct. 1—American College of Physicians, Regional, Hotel Statler, Buffalo.
Oct. 1-2—Saskatchewan Conference of the Catholic Hospital Association, Regina.
Oct. 3-8—Western Canada Institute for Administrators, Regina.
Oct. 8—Saskatchewan Hospital Association, Regina.
Oct. 9—Manitoba Conference of the Catholic Hospital Association.
Oct. 10-14—A.H.A. Institute on Advanced Accounting, Somerset Hotel, Boston.
Oct. 11-12—Manitoba Hospital Association, Royal Alexandra Hotel, Winnipeg.
Oct. 13—Manitoba Women's Hospital Aids Association, Winnipeg.
Oct. 17-21—Inter-American Congress of Surgery, Chicago.
Oct. 17-23—Clinical Congress of the American College of Surgeons, Chicago.
Oct. 24-27—Ambulatory Fracture Association, Royal York Hotel, Toronto.
Oct. 31-Nov. 1—Catholic Hospital Conference of Alberta, Calgary.
Oct. 31-Nov. 2—Ontario Hospital Association, Royal York Hotel, Toronto.
Oct. 31-Nov. 2—Canadian Association of Medical Record Librarians, Royal York Hotel, Toronto.
Nov. 2-3—Ontario Conference, C.H.A., St. Joseph's Hospital, Toronto.
Nov. 2-4—Associated Hospitals of Alberta, Palliser Hotel, Calgary.
Nov. 7-11—A.H.A. Institute for Medical Record Librarians, White House, Biloxi, Miss.
Nov. 17-18—B.C. Hospitals Association Convention, Vancouver Hotel, Vancouver.
Nov. 28-Dec. 2—A.H.A. Institute on Hospital Planning, Netherland Plaza Hotel, Cincinnati, Ohio.
Dec. 5-10—A.H.A. Institute on Hospital Personnel Relations, Edgewater Beach Hotel, Chicago.
Feb. 10-11—A.H.A. Mid-Year Conference of Presidents and Secretaries, Drake Hotel, Chicago.

Progress in V.D. Control

Steady progress has been made in Canada during the past few years in combatting the venereal disease menace. In 1946, the total number of cases reported was 41,556. In 1947, this had dropped to 33,476 and in 1948, a further drop to 27,491 was recorded. The first quarter of 1949 shows 6,307 cases reported as compared with 7,303 for the same period a year ago.

The federal government is vigorously pressing ahead with every effort to remove the threat of V.D. from Canadian homes. Under the national health program, federal V.D. control grants to the provinces have more than doubled. Before this plan went into effect, Ottawa distributed $225,000 annually. Now $500,000 has been earmarked for anti-V.D. purposes.

These grants have permitted the extension of free treatment facilities. They have provided for the salaries of additional physicians, for diagnostic and treatment services, for more free clinics and penicillin, and for additional personnel and special equipment for the clinics.

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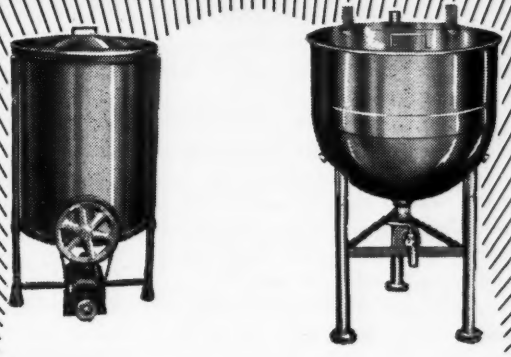
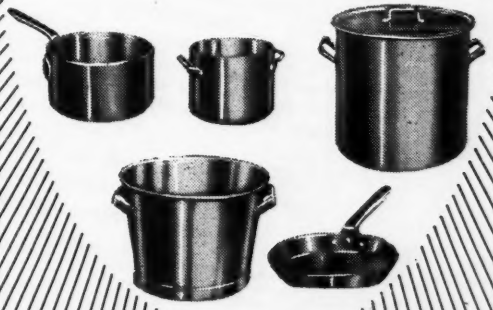
ELLETT *Stainless Steel* Equipment for MODERN HOSPITALS



Stainless steel is the most satisfactory alloy yet used in the manufacture of hospital kitchen equipment. ELLETT stainless steel mixing tanks, steam-jacketed kettles, pressure kettles and their wide range of tinned copper and stainless steel utensils that won't corrode, chip or peel, are finding favor with kitchen staffs. ELLETT ware, easy to clean and with "All-the-way-through" durability, is a lasting investment for the kitchen.

For further details of ELLETT time-proven equipment, write or wire.



ELLETT *Manufacturing Metalsmiths*
COPPER & BRASS CO., LIMITED
92 WEST SECOND AVENUE, VANCOUVER B.C.

Provincial Notes

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tal Hospital. It is expected that the walls, roof, and floors, will be completed by fall. The new addition will conform in outward appearance with the main hospital, but changes have been made in the interior design. There will be no inside walls in the wing except those enclosing bath and washrooms. Beds will be placed against two walls each four feet high. This will mean direct sunlight will reach all parts of the floor and more space will be available for the patients' use.

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MORDEN. Morden hospital district No. 21 has voted favourably for the erection of three hospitals this year. The district plans to construct a 30-bed active treatment hospital in Morden in addition to taking over the present Freemasons Hospital as a convalescent hospital, and also to build six-bed medical nursing units at Pilot Mound and Manitou.

Saskatchewan

MOOSE JAW. A finance committee of the Moose Jaw General Hospital has begun a campaign to raise funds for the building of a new $600,000 wing. On July 30th, they held a tag day for the purpose of raising money for the hospital and also to give publicity to the project. The committee estimates that it will take about two years to raise the money required.

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WALDHEIM. On July 6th, the new Waldheim Hospital was officially opened. About 700 citizens attended the ceremony and were later conducted through the building. Gifts of sheets, pillow-cases, towels, baby layettes, blankets, glassware, and canned fruits were on display. The visitors were served lunch, and the proceeds of this as well as the proceeds from the parking fees and a raffle were directed to the hospital funds. A total of $542 was collected.

Alberta

CALGARY. The new $550,000 wing of the Holy Cross Hospital is scheduled to open this fall. It will provide 74 additional beds and 23 bassinets. The wing will contain 9 operating rooms, a new obstetrical department complete with nursery for premature babies, a medical assembly hall, dining-rooms, and private and semi-private rooms. On the fourth floor, there will be a 45-bed children's department which will be wired for sound and radio.

British Columbia

COBBLE HILL. The Victoria Gyro Club has presented the Queen Alexandra Solarium with three cottage-type nurses' residences. The cottages, each a self-contained unit with living-room, bedroom, kitchen and bathroom, were built at a cost of $55,000. A grant of $25,000 was

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Provincial Notes

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received from the provincial government and the rest of the money was raised by the Gyro Club from hole-in-one contests started in 1940.

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VANCOUVER. Mr. F. J. Fish, for over 20 years director of the medical records department of the Vancouver General Hospital, has now as an administrative assistant been appointed liaison officer between the hospital and the B.C. Hospital Insurance Service. The vacancy thus created has been filled by Mrs. Virginia D. Stannard, R.R.L., of Standford University Hospital, San Francisco.

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VERNON. The new 117-bed Vernon Jubilee Hospital, completed this month, has been constructed at a cost of approximately $550,000. In this modern structure, no ward except that for children contains more than four beds and all ceiling space is covered with acoustic tiling to prevent noise. Wards and private rooms alike are supplied with radios, writing tables and easy chairs. J. O. Dale, formerly secretary-manager of the Lady Minto Hospital, Melfort, Sask., has been appointed administrator.

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VICTORIA. Provincial government architects will soon start work on plans for the $4,000,000 mental hospital at Colquitz, slated for construction next year. The plans call for a 500-bed administration building, a dangerous patient wing with 100 beds, and a wing for "disturbed" patients with 200 beds. The project would also include a boiler house, kitchens, bake shop, dining-room, laundry, stores, recreational therapy block, nurses' home, farm buildings and other units.

Do Figures Lie?

The instructor was striving to drive home some truths. "Figures can't lie," he declared. "For instance, if one man can build a house in twelve days, twelve men can build it in one day."

A puzzled student interrupted: "Then 288 men can build it in one hour, 17,280 in one minute, and 1,036,809 in one second."

While the instructor was still gasping, the ready reckoner went on: "And if one ship can cross the Atlantic in six days, six ships can cross it in one day. 'Figures can't lie,' can they?"—*Davis Nursing Survey.*